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SAINT VINCENT AND THE GRENADINES HEALTH SYSTEM AND PRIVATE SECTOR ASSESSMENT



February 2012

This publication was produced for review by the United States Agency for International Development. It was prepared by Michael Rodriguez, Taylor Williamson, Abigail Vogus, Elizabeth Macgregor-Skinner, Donna-Lisa Pena, Anneke Wilson, and Sharon Nakhimovsky for the Health Systems 20/20 Project.

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CONTENTS

Acronyms	ix
Acknowledgments	xi
Foreword.....	xii
Executive Summary	xiv
I. Assessment Methodology	25
1.1 Framework for the Health System And Private Sector Assessment Approach	25
1.2 Health System and Private Sector Assessment Process	25
1.2.1 Phase 1: Prepare for the Assessment	25
1.2.2 Phase 2: Conduct the Assessment	26
1.2.3 Phase 3: Analyze Data and Prepare the Draft Report.....	26
1.2.4 Phase 4: Discuss Findings with Local Stakeholders	26
2. Country Background and Health Systems Profile.....	27
2.1 Overview of Saint Vincent and the Grenadines.....	27
2.1.1 Demographics and Population Dynamics	28
2.1.2 Mortality and Morbidity	29
2.1.3 Reproductive Health and HIV	29
2.2 Political and Macroeconomic Environment.....	31
2.3 Business Environment and Investment Climate	33
2.4 Health System Structures	33
2.5 Service Delivery Structure	34
2.5.1 Health Facilities	35
2.5.2 HIV/AIDS Services	35
2.6 Health Systems Strengthening Capacity.....	36
3. Governance.....	39
3.1 Overview of Governance in Saint Vincent.....	40
3.1.1 Worldwide Governance Indicators	40
3.1.2 Health Governance	41
3.2 Policy and Regulatory Environment	41
3.2.1 Major Health Legislation	41
3.2.1 Civil Society Environment	43
3.2.2 Participation and Regulation of the Private Sector	44
3.2.3 Proposed Legislation.....	46
3.3 Government Structures	47
3.4 Voice and Responsiveness.....	48
3.5 Recommendations	49
3.5.1 Short-Term Recommendations	49
3.5.2 Longer-Term Recommendations.....	50

4. Health Financing.....	51
4.1 Overview of Health Financing	51
4.2 Health Financing Indicators and Trends in Saint Vincent.....	52
4.2.1 Total Health Expenditure in Saint Vincent.....	52
4.2.2 Government Contribution to Health Financing.....	53
4.2.3 Government Spending on HIV/AIDS.....	54
4.2.4 Donor Contributions to Health	55
4.2.5 Out-of-Pocket Spending.....	57
4.3 Health Financing and Management Capacity.....	58
4.4 Health Financing Functions in Saint Vincent	59
4.4.1 Resource Mobilization.....	59
4.4.2 Risk Pooling	60
4.4.3 Resource Allocation and Purchasing.....	63
4.5 Recommendations	64
4.5.1 Short-Term Recommendations	64
4.5.2 Longer-Term Recommendations.....	65
5. Service Delivery.....	67
5.1 Structure of the Health Service Delivery	67
5.2 Priority Health Areas.....	70
5.2.1 HIV/AIDS Services	70
5.2.2 Mental Health	71
5.2.3 Chronic Noncommunicable Diseases	71
5.3 Organization of Service Delivery.....	72
5.3.1 Integration of Services into Primary Care.....	72
5.3.2 Vertical Programs	73
5.3.3 Referral Systems and the Care Continuum	74
5.3.3 Health Outcomes	74
5.3.4 Availability of Services	75
5.4 Quality Assurance	76
5.5 Community-Level Participation and Care	78
5.6 Recommendations	78
5.6.1 Short-Term Recommendations	78
5.6.2 Longer-Term Recommendations.....	79
6. Human Resources for Health	81
6.1 Human Resources Profile	82
6.2 Health Policies	82
6.3 Health Workforce	83
6.3.1 Distribution of Health Workers.....	83
6.3.2 Distribution by Level of Care.....	84
6.3.3 Public vs. Private	85
6.4 Human Resource Development.....	86
6.4.1 Human Resources Information Systems.....	86
6.4.2 Recruitment and Absenteeism	87
6.4.3 Supervision	87

6.5	Workforce Development.....	88
6.5.1	Pre-Service Education.....	88
6.5.2	In-Service Education.....	89
6.6	Recommendations	89
6.6.1	Short-Term Recommendations	89
6.6.2	Longer-Term Recommendations.....	89
7.	Management of Pharmaceuticals and Medical Supplies	91
7.1	Overview of the Medical Products Management System	91
7.1.1	Registration and Regulations.....	92
7.1.2	Pharmacovigilance and Adverse Drug Reaction	94
7.2	Medicines and Medical Products Supply	94
7.2.1	Public Sector Supply.....	95
7.2.2	Private Sector Supply.....	97
7.3	Rational Use	98
7.4	Availability and Access.....	99
7.5	Financing	100
7.6	Recommendations	101
7.6.1	Short-Term Recommendations	101
7.6.2	Longer-Term Recommendations.....	102
8.	Health Information Systems	103
8.1	Overview	103
8.2	Health Information Systems Support Team Structure and Responsibilities	104
8.3	Existing Platforms and Record Keeping	104
8.4	Indicators	106
8.4.1	Vital Statistics in Reporting	107
8.4.2	Surveys and the Census	107
8.5	Reporting Resources	108
8.5.1	Finances	108
8.5.2	Policies and Regulations	108
8.5.3	Technical Infrastructure.....	109
8.6	Data Collection	109
8.6.1	Availability	109
8.6.2	Data Flow and Consolidated Reporting.....	109
8.6.3	Quality	110
8.6.4	Private Health Sector Reporting.....	110
8.7	Data Analysis	111
8.8	Use of Information for Decision-Making	111
8.8.1	Policies and Governance.....	111
8.8.2	Planning and Budgeting.....	112
8.9	Recommendations	112
8.9.1	Short-Term Recommendations	112
8.9.2	Longer-Term Recommendations.....	113
9.	Private Sector Contributions to Health.....	115
9.1	Introduction and Overview.....	115

9.1.1 Private Health Service Delivery	116
9.1.2 Cost of Services	117
9.2 Private Sector Role in the Supply Chain	117
9.2.1 Private Pharmacies	117
9.2.2 Pharmacy Distributors and Wholesalers.....	118
9.2.3 Medical Support Services.....	119
9.3 Governance and Policy Environment.....	119
9.3.1 Public-Private Engagement to Develop Policy.....	119
9.3.2 Regulation of the Private Sector	120
9.3.3 Dual Practice	121
9.4 Private Financing for Health.....	121
9.5 Contributions of Private Companies to Health	122
9.5.1 Charitable Contributions.....	122
9.5.2 Strategic Contributions.....	123
9.5.3 Workplace Programs	123
9.6 Public-Private Engagement.....	123
9.6.1 Subcontracted Services Through the Private Sector.....	124
9.6.2 Public-Private Partnership: The World Pediatric Project.....	124
9.6.3 Facilitating Public-Private Engagement.....	125
9.6.4 Opportunities for Public-Private Partnership	125
9.7 Recommendations	126
9.7.1 Short-Term Recommendations	126
9.7.2 Longer-Term Recommendations.....	127
10. Synthesis and Cross-Cutting Themes.....	129
Annex A: Report on the Health System and Private Sector Assessment Validation and Prioritization Workshop in Saint Vincent and the Grenadines	133
Annex B: Key Issues Regarding HIV/AIDS in Saint Vincent and the Grenadines	149
Annex C: World Bank Health Financing Indicators.....	152
Annex D: Bibliography	153

LIST OF TABLES

Table 2.1: Demographic Indicators in Saint Vincent Compared With the Latin America and the Caribbean Regional Average for Developing Nations.....	28
Table 2.2: Mortality Indicators in Saint Vincent Compared With the Latin America and the Caribbean Regional Average	29
Table 2.3: Reproductive Health Indicators in Saint Vincent Compared With the Latin America and the Caribbean Regional Average.....	30
Table 2.4: Economic Indicators in Saint Vincent Compared With the LAC Regional Average.....	32
Table 3.1: World Bank Worldwide Governance Indicators: Saint Vincent and the Grenadines.....	40
Table 3.2: Key Health Legislation.....	42

Table 3.3: Selected Health-Focused Civil Society Organizations in Saint Vincent.....	43
Table 3.4: Key Legislative Updates	46
Table 4.1: Ministry of Health, Wellness and the Environment Donor Contribution Estimates 2010–2013.....	56
Table 4.2: Current Health Insurance coverage (private)	61
Table 5.1: First Place Visited for Medical Attention by Quintiles (percent).....	69
Table 5.2: Service Delivery Indicators for Saint Vincent compared to Latin America and the Caribbean Region.....	75
Table 6.1: Public Sector Human Resources for Health Workers per 10,000 Population by PAHO Occupational Groupings	83
Table 6.2: Health Workers in Primary, Secondary, and Tertiary Care	85
Table 6.3: Health Workers Registered with the Registration Councils ^a in Saint Vincent by Occupational Category	86
Table 7.1: Pharmaceutical Expenditure Indicators for Saint Vincent, 2000	100
Table 10.1: Cross-Cutting Recommendations.....	129
Table C1: Selected Economic and Health Expenditure Indicators, Saint Vincent and the Grenadines, 2000–2009	152

LIST OF FIGURES

FIGURE 2.1: MAP AND PARISHES OF SAINT VINCENT AND THE GRENADINES...	27
Figure 2.2: Adolescent Fertility Rates in Saint Vincent Compared with Other Countries, the Latin America and the Caribbean Region, and Middle-Income Countries.....	30
Figure 2.3: Organizational Structure of the Ministry of Health, Wellness and the Environment, 2011	34
Figure 4.1: Total Health Expenditure as Percentage of Gross Domestic Product	52
Figure 4.2: Health Expenditure Per Capita in the Organization of Eastern Caribbean States Countries (US\$)	53
Figure 4.3: Government Health Expenditure Per Capita (Average Exchange Rate US\$)	53
Figure 4.4: Government Health Expenditure as Percentage of Total Government Expenditure.....	54
Figure 4.5: Domestic Spending on HIV/AIDS in Saint Vincent.....	55
Figure 4.6: Out-of-Pocket Payments vs. Gross National Income Per Capita, 2008	57
Figure 4.7: Budgeting Process for the MOHE in Saint Vincent.....	63
Figure 5.1: Diagram of the Public Sector Health Facilities.....	68
Figure 5.2: Percentage of Attendance for Diabetes and Hypertension at Selected District Medical Clinics, 2010	72
Figure 7.1: Pharmaceutical Supply Chain for Saint Vincent.....	94
Figure 7.2: Average Percentage Unit Cost Reduction For a Market Basket of 20 Popular Drugs 2001/02 Versus Individual Country Prices.....	95
Figure 8.1: Clifton Health Clinic Data Wall, Union Island	105
Figure 8.2: Syndromic Diagnosis Flowchart from District Hospital	110

ACRONYMS

A&E	Accidents and Emergency
ADR	Adverse Drug Reactions
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Treatment
ARV	Antiretroviral
BAICO	British American Insurance Company
CARICAD	Caribbean Center for Development Administration
CARICOM	Caribbean Community
CDB	Caribbean Development Bank
CHAA	Caribbean HIV/AIDS Alliance
CHART	Caribbean HIV/AIDS Regional Training Network
CICAD	Inter-American Drug Abuse Control Commission
CLICO	Colonial Life Insurance Company
CME	Continuing Medical Education
CMO	Chief Medical Officer
CMS	Central Medical Stores
CNO	Chief Nursing Officer
CSO	Civil Society Organization
DMO	District Medical Officers
E-GRIP	E-Government Regional Integration Project
EC\$	Eastern Caribbean Dollar
EDF	European Development Fund
EHR	Electronic Health Record
EKG	Electrocardiogram
EML	Essential Medicines List
EU	European Union
FOIA	Freedom of Information Act
GDP	Gross Domestic Product
GOSVG	Government of Saint Vincent and the Grenadines
HIS	Health Information Systems
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPIU	Health Planning and Information Unit
HRH	Human Resources for Health
HRIS	Human Resources Information System
HRM	Human Resource Management
HSA	Health Systems Assessment
HSS	Health Systems Strengthening
ICT	Information and Communications Technology

ILO	International Labor Organization
I-TECH	International Training and Education Center for Health
LAC	Latin America and the Caribbean
M&E	Monitoring and Evaluation
MCMH	Milton Cato Memorial Hospital
MOF	Ministry of Finance and Economic Planning
MOHE	Ministry of Health, Wellness and the Environment
NAP	National AIDS Program
NAS	National AIDS Secretariat
NCD	Noncommunicable disease
NGO	Nongovernmental Organization
NHA	National Health Accounts
NHI	National Health Insurance
NIS	National Insurance Service
OECS	Organization of Eastern Caribbean States
OOP	Out-of-Pocket
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership Against HIV and AIDS
PEPFAR	President's Emergency Plan for HIV Relief
PLHIV	People Living with HIV
PNC	Postnatal Care
PPS	Pharmaceutical Procurement Service
PSA	Private Sector Assessment
PSC	Public Service Commission
PRISM	Performance of Routine Information Systems and Management
RDQA	Routine Data Quality Assessment
SCD	Service Commission Department
SHOPS	Strengthening Health Outcomes through the Private Sector
STG	Standard Treatment Guidelines
STI	Sexually Transmitted Infection
SVEF	Saint Vincent Employers Federation
SVG	Saint Vincent and the Grenadines
SVGHIS	Saint Vincent and the Grenadines Health Information System
UN	United Nations
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	United States Agency for International Development
UWI	University of the West Indies
VCT	Voluntary Counseling and Testing
WGI	World Governance Indicators
WHO	World Health Organization
WIFA	Windward Islands Farmers Association
WPP	World Pediatrics Partnership
WTTC	World Travel and Tourism Council

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- Government: Ministry of Health, Wellness and the Environment, Ministry of Finance and Economic Planning, Ministry of Tourism, Ministry of Family Affairs, the Public Services Commission, National Insurance Services, and Invest SVG
- Public sector health facilities: Milton Cato Memorial Hospital, the Mental Health Rehabilitation Center, Lewis Punnett Geriatrics Center, Chateaubelair Hospital and Health Center, Clifton Health Center, Calliaqua Health Center, and Georgetown Hospital and Health Clinic
- Medical, Pharmacists', and Nurses' Councils
- Nongovernmental and civil society organizations
- Doctors and dentists in private practice
- Private pharmacies
- Private insurance companies
- Private businesses
- Private medical training institutions
- Private laboratories

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This assessment report was prepared collaboratively by the different members of the assessment team. Abigail Vogus drafted the Country Overview and Pharmaceutical Management chapters, and edited the Service Delivery chapter; Taylor Williamson drafted the Governance and Human Resources chapters; Donna-Lisa Pena drafted the Health Financing chapter; Anneke Wilson drafted the Service Delivery chapter; Michael Rodriguez drafted the Health Information Systems chapter, and Elizabeth Macgregor-Skinner drafted the chapter on Private Sector Contributions to Health. Michael Hainsworth contributed to the Human Resources for Health chapter; Sharon Nakhimovsky revised several chapters and provided overall editorial support.

FOREWORD

In 2009 the United States Government supported a process to develop the United States-Caribbean Regional HIV and AIDS Partnership Framework 2010–2014 (Partnership Framework) together with 12 Caribbean countries: Antigua and Barbuda, the Bahamas, Barbados, Belize, Dominica, Grenada, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, and Trinidad and Tobago. Development of the Partnership Framework involved participation from ministries of health, national AIDS programs, regional organizations such as the Pan Caribbean Partnership Against HIV and AIDS (PANCAP) and the Organization of Eastern Caribbean States (OECS), and nongovernmental and private sector stakeholders. The Partnership Framework is aligned with national strategic plans and the PANCAP Caribbean Strategic Framework.

A major goal of the Partnership Framework is to move the region toward greater sustainability of HIV/AIDS programs. Obtaining results in this area will be challenging, given that most country governments currently provide limited national budget resources to their own HIV/AIDS programs, relying to a large degree on external aid. While there are six United States government agencies supporting implementation of the Partnership Framework, the United States Agency for International Development/Eastern Caribbean (USAID/EC) provides support for health systems strengthening (with particular emphasis on health financing) and private sector engagement. Both these efforts are closely linked to sustaining the HIV response in the region.

As a part of the Partnership Framework, USAID/EC asked the Health Systems 20/20 and the Strengthening Health Outcomes through the Private Sector (SHOPS) projects to conduct integrated health system and private sector assessments in Saint Lucia, Grenada, Saint Kitts and Nevis, Antigua and Barbuda, Dominica, and Saint Vincent and the Grenadines. The assessments identify opportunities for technical assistance, which are aimed at improving the capacity of these countries to effectively lead, finance, manage, and sustain the delivery of quality health services, including HIV prevention, care, and support.

USAID/EC has requested that the SHOPS project, USAID's global flagship private sector engagement project, establish a baseline of private sector engagement in HIV/AIDS that will inform future regional and country support for maximizing contributions from this sector in the eastern Caribbean. USAID/EC has asked Health Systems 20/20, USAID's global flagship health systems strengthening project, to determine opportunities for improving health financing systems, ensuring the sustainability of funding for the HIV/AIDS response, and strengthening financial tracking and management procedures in the region. The integrated health system and private sector assessment approach is specifically used to pinpoint areas where the private sector can be leveraged to strengthen health systems, sustain national HIV responses, and contribute to improved health outcomes.

The assessment methodology is a rapid, integrated approach covering six health systems components: governance, health financing, service delivery, human resources for health, management of pharmaceuticals and medical supplies, and health information systems. Special emphasis is placed on the current and potential role of the private sector within and across each health system building block. An extensive literature review was conducted for each country and in-country interviews with key stakeholders were used to validate and augment data found in secondary sources. The assessments are guided by an intensive stakeholder engagement process. Following the preparation of a draft assessment report, preliminary findings and recommendations are validated and prioritized at in-country stakeholder workshops. Stakeholders interviewed and engaged throughout the assessment process include government representatives, development partners, nongovernmental organizations, professional

associations, health workers in the public and private sector, civil society organizations, and private sector businesses.

The assessments have been conducted in close collaboration and cooperation with the Pan American Health Organization (PAHO), the Health Resources and Services Administration (HRSA), the International Training and Education Center for Health (I-TECH), the Caribbean HIV/AIDS Regional Training Network (CHART), and USAID. Representatives of these organizations joined assessment teams, contributed to the assessment reports, and have assisted with identifying opportunities for technical assistance. Health Systems 20/20 and SHOPS wish to express gratitude to these organizations, to ministries of health in participating countries, and to all in-country stakeholders for their intensive engagement and contribution to the assessments.

EXECUTIVE SUMMARY

PURPOSE OF THE ASSESSMENT

Saint Vincent and the Grenadines (henceforth, Saint Vincent) is one of 12 Caribbean countries joining efforts with the United States Government in the United States-Caribbean Regional HIV and AIDS Partnership Framework 2010–2014 (Partnership Framework). The United States Agency for International Development (USAID) is working through two projects, Health Systems 20/20 and Strengthening Health Outcomes through the Private Sector (SHOPS), to provide a variety of health systems strengthening technical assistance to countries in the eastern Caribbean, as part of this Partnership Framework. To identify priorities for this technical assistance, the two projects conducted an integrated health systems and private sector assessment. Additional partners in this effort included the Pan American Health Organization (PAHO), the International Training and Education Center for Health (I-TECH), and the Caribbean HIV/AIDS Regional Training Network (CHART). The assessment described in this report is a first step toward improving the capacity of Saint Vincent to effectively lead, finance, manage, and sustain the delivery of quality health services, including HIV prevention, care, and treatment. Important to the country's capacity to carry out these roles is better understanding and catalyzing private sector contributions to health. While the functioning of the broader health system is the focus of the assessment, particular attention was paid to sustaining the country's HIV response.

COUNTRY OVERVIEW

Saint Vincent is an upper-middle-income multi-island state in the eastern Caribbean with a population of approximately 109,000. As with many of its neighboring countries, primary care service coverage indicators are extremely strong, with universal coverage of vaccines for key childhood illnesses and skilled attendance at delivery. The country is experiencing epidemiological transitions, as seen in the increasing burden of noncommunicable diseases (NCDs), which account for the top five causes of death, and in the increasing average age of the population. The estimated prevalence of HIV in Saint Vincent is 1 percent, but stigma against individuals with HIV and AIDS continues to persist across the islands. Health services in Saint Vincent are delivered through publicly managed primary health clinics, rural district hospitals, the centrally located secondary hospital (Milton Cato Memorial Hospital [MCMH]), and a number of private sector clinical offices. The country's only private hospital, a 12-bed facility, ceased operations in 2011. Like many other Caribbean countries, many citizens of Saint Vincent travel abroad for tertiary care. Though the majority of health service providers are in the public sector, the private sector also plays a prominent and growing role; physicians in Saint Vincent commonly practice in both the public and private sectors.

METHODOLOGY

Health systems and private sector experts from the SHOPS and Health Systems 20/20 projects, as well as I-TECH and PAHO, conducted an integrated rapid assessment of Saint Vincent's health system according to the six building blocks of the World Health Organization (WHO) health systems strengthening framework: governance, health financing, service delivery, human resources for health (HRH), management of pharmaceuticals and medical supplies, and health information systems (HIS). Examination of the current and potential role of the private sector in the health system was incorporated into this approach. In an effort to promote efficiency, an extensive review of the literature pertaining to the health system, and HIV/AIDS services in particular, was conducted prior to the team's arrival in the country. Existing information was then validated and expanded upon through interviews

with over 80 key stakeholders representing the public, non-profit, and for-profit segments of the health system in Saint Vincent.

KEY FINDINGS AND RECOMMENDATIONS

CROSS-CUTTING FINDINGS AND RECOMMENDATIONS

Efficiency in public health care and referral systems

The Saint Vincent health system is providing comprehensive and effective coverage for primary care services to its population even though the system must serve multiple islands. Challenges remain, however, in providing diagnostic services and secondary and tertiary care in a cost-effective and high-quality manner. As chronic noncommunicable diseases (NCDs) such as diabetes, hypertension, and cardiovascular disease place a greater burden on the population, the need for effective management strategies to combat them grows too. Key among the strategies for addressing this challenge in Saint Vincent should be supporting patients with NCDs in the communities where they live and where they can be managed more cost-effectively, rather than traveling to the MCMH to have blood tests conducted, x-rays taken, or prescriptions filled. By the same token, more than 92 percent of deliveries take place at MCMH, even though district hospitals are equipped, trained, and staffed to handle routine deliveries. There is not currently an effective referral system in place to direct primary care visits to health clinics or district hospitals rather than to MCMH.

Recommendation: Develop an enforceable referral policy to divert patients from MCMH and to the health clinics (or the new Stubbs Polyclinic) for appropriate outpatient and after-hours primary care. Potential policies could include imposing (and collecting) higher user fees on patients who choose to bypass the local primary care facilities in favor of MCMH. At the same time, steps need to be taken to ensure that key services are available at primary health clinics/district hospitals. For example, implementing a rotating phlebotomy service could facilitate the drawing of blood at health clinics/district hospitals, which could then be taken to MCMH for lab tests. The roll-out of the electronic health management information system (SVGHIS) across all public health facilities in Saint Vincent, through which test results can be electronically reported back to primary health care sites, will mean that patients can receive their results locally as well.

Availability and use of key data in planning

A primary tool for monitoring and evaluation of the impact of services being provided in various settings is data, particularly financial data. Much of the routine health data from health clinics and hospitals in Saint Vincent is regularly compiled and reported centrally to the Ministry of Health, Wellness and the Environment (MOHE). Staff at the MOHE at this time, however, do not have the bandwidth and capacity to evaluate in a timely manner and disseminate widely the extensive amounts of data that are received routinely. This issue is difficult to address, because in order to advocate for additional resources to support capacity building for analysis and planning expertise, analysis and planning of such needs is required. As external funding sources for health programs decline, such as reductions in Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) support for HIV/AIDS programs, the sustainability of such programs needs to be carefully understood and planned for. Determining the long-term costs of sustaining these programs should be a critical short-term objective for Saint Vincent.

Recommendation: Initiate a costing exercise to begin documenting the cost of providing key health services across multiple settings. The costing data will provide an initial piece of the planning puzzle, allowing for comparisons of the cost of services, the health outcomes achieved, and the budgetary allocations supporting the provision of those services. Further, having unit cost data will allow the MOHE to begin exploring where services might be most cost-effectively

provided. The exploration will include engaging in dialogue with private sector providers to evaluate whether some services ought to be contracted out to private providers, such as laboratory tests requiring hard-to-maintain equipment. Another component that the costing data will support is human resources planning, which is a critical need within the MOHE.

Dialogue and partnership with private health sector stakeholders

The assessment team identified several examples of the private sector medical practices supporting provision of health services to Vincentians in a way that benefits public interest while also satisfying business needs. One example is the Mustique Company, a private entity that owns and operates the Mustique Clinic, which is the only health clinic located on Mustique Island. While primarily intended to provide care for Mustique Company employees, who hold company health insurance and who live on the island, the clinic is also open to everyone on the island, including residents, construction workers, and tourists who pay for services out-of-pocket (OOP) or through external insurance, except during the clinic's free hours. In this manner, the Mustique Company ensures that its employees get efficient health care, while also filling in for the public sector, which does not operate a health facility on the island. Another example is the World Pediatric Project, which is an international nongovernmental organization (NGO) that will provide specialty pediatric services at MCMH in collaboration with other public and private partners. The services, such as surgeries, are provided at no cost to the patients, but do utilize MCMH resources in the process. There are potential opportunities for the MOHE to leverage these public-private relations as another resource to achieve prioritized national health targets.

Recommendation: Formally designate and empower a staff member within the MOHE to act as the public-private liaison. The primary objective of this role would be to foster a collaborative dialogue between the MOHE and private sector entities to plan, evaluate, and support health improvement activities across Saint Vincent.

Revision of critical health policies and acts

The Saint Vincent health system has been operating with outdated public health acts and partially developed regulations that have stopped short of providing effective oversight guidelines, responsibility, and authority. Though the Strategic Plan for Health 2007–2012 called for the review and updating of health legislation and regulations by 2012, to date critical pieces of legislation remain stuck in various stages of implementation, with consequences for the efficiency and efficacy of Saint Vincent's health system. For example, the current Pharmacy Act defines how to register and open a pharmacy, but does not structure the process by which pharmacies should be monitored, evaluated, or sanctioned, and the regulations linked with the Pharmacy Act have not been passed. Also, the Medical Registration Act of 1886 sets up the regulatory practice for medical care, including private physicians, but no private providers interviewed could recall active regulation enforcement from the MOHE and several voiced concern that, without updated regulations and better enforcement, it was hard to close unethical medical practices or facilitate data sharing and cooperation among practitioners.

Recommendation: Review and update central components of the health sector regulatory framework. This will require engaging in a collaborative dialogue with the Attorney General's office, where regulations are developed and must be approved, and consulting with public and private providers and the Medical Councils to identify and catalog the legislation that needs to be updated most urgently. In addition, the MOHE should negotiate a cost recovery policy with private sector providers using public sector facilities to ensure that their collaboration is sustainable.

Presented below are additional findings and recommendations for strengthening the Saint Vincent health system across each building block of the WHO health systems framework. In the rest of the report, separate chapters provide full findings and recommendations (presented as short-term and longer-term) for each building block, with another chapter solely focused on private sector contributions to health.

FINDINGS AND RECOMMENDATIONS BY BUILDING BLOCK

Governance

Effective governance of a health system ensures that rules governing policy development, programs, and practices in the provision of health care are implemented to achieve health sector objectives. This assessment considers state actors, health service providers, beneficiaries of services, and regional entities to understand the way that they interact to guide health service delivery. Advocacy in Saint Vincent is possible through radio call-in shows and direct contact with legislators, who are accessible to citizens on a frequent basis. The legislative framework that provides the backbone of the health system is outdated and does not reflect current issues. Many pieces of legislation are in various phases of revision. In some cases, regulations to support enacted legislation such as the Pharmacy Act have been drafted, with the intention of making policies address current inefficiencies and reflect the changing health needs in Saint Vincent. However, few have actually been passed into law and delays have led to weak regulations for some classes of health workers. The delay in passage of the Freedom of Information Act (FOIA), and the lack of a substitute, hinders citizens' access to government data and information, limiting government transparency. Based on these findings, this assessment recommends that the government of Saint Vincent improve transparency by passing and implementing the FOIA and updating regulations to support effective oversight.

Key findings and recommendations in the area of health governance are as follows:

Findings	Recommendations
<ul style="list-style-type: none">• Citizen engagement with the health system is informal• Legal framework for the health system is outdated, and does not reflect current issues• Hospital management structure does not promote accountability, flexibility, and efficiency• Government transparency is hindered by the absence of a FOIA	<ul style="list-style-type: none">• Develop a dissemination strategy for the MOHE Annual Report• Implement new legislation and legislative updates to strengthen governance structures• Strengthen ties with the Attorney General's office to prioritize key health legislation• Consider alternative governance models for the MCMH• Develop stronger mechanisms for engaging civil society organizations and citizens

Health Financing

Health financing, defined as the mobilizing, pooling, and allocating of funds to cover the needs of a country's population, is a critical component of a health system, and its adequacy affects a country's ability to ensure access to quality health care. According to existing indicators, total health expenditure per capita has risen steadily in Saint Vincent, but government expenditure as a percentage of total government expenditure has fallen since 2000. Because Saint Vincent has not completed a general National Health Accounts (NHA) analysis, it is hard to estimate current levels of OOP health expenditure or understand whether the population is protected from burdensome health care costs. This is particularly relevant in a country where 30 percent of the population falls below the poverty line (Kairi Consultants Limited 2009). This assessment found that the MOHE lacks the human and technical capacity to consider different financing options and use data to inform strategic planning and budgeting. These limitations might also affect the country's ability to implement national health insurance (NHI), which Vincentian policymakers envision will one day provide universal basic health care coverage (currently only 9 percent of the Vincentian population has health insurance, through four private companies). In the longer term, increasing the public sector's capacity to review and analyze health financing data regularly and apply the findings of these analyses to the development and implementation of health financing strategies will likely improve the functioning of the health system.

Key findings and recommendations in the area of health financing are as follows:

Findings	Recommendations
<ul style="list-style-type: none">Plans exist to design an NHI scheme and incorporate it into the structure of the National Insurance Service (Social Security)User fees are part of the revenue generation strategy though they currently do not contribute significantly to government revenueUnderstanding of health financing and financing options is limited; the amount of data available is also limitedThe level of OOP expenditure and the contribution of the private sector is unknown	<ul style="list-style-type: none">Conduct broad, systematic review of health financing options and packagesConduct a cost-benefit analysis of selected service provision in public and private sectorsConduct an NHA analysisInstitutionalize NHA and the tracking of health expendituresBuild MOHE's leadership capacity in health financingDevelop a health financing strategy

Service Delivery

Health service delivery is the most visible aspect of a health system because it is typically where users interface with the health system. Service delivery systems should aim to ensure access, quality, safety, and continuity of health care. Saint Vincent has good coverage and affordable access to primary and basic secondary care services. However, primary care service provision is limited in the availability of doctors, diagnostics, and opening hours, all of which appear to contribute to users circumventing local/rural public health clinics and going directly to the main hospital, MCMH, or to the growing private sector. The HIV and Sexually Transmitted Infections (STI) clinic at MCMH is an important facility, being the only one in Saint Vincent that provides services beyond voluntary counseling and testing (VCT) for HIV care and treatment. However, the set-up at this clinic does not allow for confidentiality of these services, which facilitates rather than blocks stigma against people living with HIV (PLHIV). The health sector has undergone a series of reforms over the last couple of decades to respond to the changing epidemiological profile and the aging population. The reforms included introducing or increasing user fees for health services and pharmaceuticals, improving nursing education and hospital governance, and studying the feasibility of an NHI plan. The reform process is still ongoing. Supervisory systems are in place, with reports on the level of service delivery regularly submitted to the MOHE. However, little feedback is provided to facility staff based on the data submitted. Saint Vincent might benefit from implementing supportive supervision to address current limitations in quality assurance and feedback mechanisms.

Key findings and recommendations in the area of service delivery are as follows:

Findings	Recommendations
<ul style="list-style-type: none">• Primary health care is generally strong and community-based care is ensuring access, though limited diagnostics and hours open create some problems in access• PLHIV face challenges accessing services due to stigma and discrimination• The MCMH is overutilized for primary care and rural hospitals are underutilized; this appears to be due to the lack of consistent/daily access to doctors and diagnostics at the primary care level and at rural hospitals• Inconsistent collection of user fees and lack of clarity on application of exemption rules affect management and performance at public facilities• Quality improvement mechanisms are weak	<ul style="list-style-type: none">• Reorganize the MCMH outpatient specialty clinic in order to reduce stigma• Standardize exemption policies for prescriptions and hospital services• Create clinical practice guidelines for priority health areas to promote standardized, quality care and more cost-effective treatments• Promote the use of rural hospitals and health clinics• Implement supportive supervision which can support quality improvements and provide feedback to health facility staff

Human Resources for Health

HRH impacts the availability, costs, and quality of health service delivery. Data collected through the assessment suggests that, while there are sufficient numbers of clinical care providers on the islands, significant personnel and structural challenges exist. For example, calls in the Strategic Plan for Health 2007–2012 to develop an HRH strategic plan have not yet been answered. One possible result is that, despite the estimated 20 percent unemployment rate among nurses in Saint Vincent, the country still promotes a deliberate policy of training nurses to work abroad. In contrast to the oversupply of nurses, Saint Vincent faces shortages of specialist auxiliary staff, including health educators, nutritionists, and environmental health workers. Finally, structural issues also hinder effective human resources management, most notably the time-consuming and circuitous process for hiring staff into new positions. The Service Commission Department (SCD) is currently adding a human resources management module to an existing government management software package for all civil servants, but it is not yet operational. Recommendations to address these shortcomings include targeted interventions, such as streamlining the hiring process, and general HRH-wide strategic planning, allowing for clarification of roles and rationalization of educational investments.

Key findings and recommendations in the area of HRH are as follows:

Findings	Recommendations
<ul style="list-style-type: none">• Saint Vincent has a solid, consistent nurses training program that produces a surplus of health workers• The human resources component of SmartStream is currently underutilized. This is being addressed using external assistance. Extensive training for health workers has resulted in widespread capacity for providing VCT• Legislation governing health professions provides basic guidelines on licensing, but needs strengthening in guidance on education and re-licensing• Procedures for replacing departing staff are cumbersome and time-consuming• An HRH strategic plan has not yet been developed or implemented, though it was identified as a need in the Strategic Plan for Health• Dual practice among physicians is largely unregulated resulting in a perception by the private sector that a subsidization of private practice for some providers takes place	<ul style="list-style-type: none">• Streamline the hiring process through statutory reform or updating guidelines• Coordinate with the SCD to clarify the roles of each human resources information system (HRIS) (SmartStream and SVGHIS) in managing human resources in order to avoid duplication• Develop and implement an HRH strategic plan• Rationalize nurse training needs to match demand• Update legislation on health providers to include a continuing education requirement, regular licensing, and improved disciplinary procedures• Clarify the responsibilities of public sector doctors who have private practices

Management of Pharmaceuticals and Medical Supplies

Proactive management of pharmaceuticals and medical supplies is essential to a functional health system. Good pharmaceutical management is also important to guaranteeing that the medicines available are safe and efficacious and kept in the correct form and condition to maintain effectiveness. In Saint Vincent, many recent investments, such as the creation of an Essential Medicines List, investments in lab strengthening, and the hiring of a pharmacovigilance officer, have strengthened the pharmaceutical and medical supply sector. More improvements could be made, particularly in the areas of regulation and inventory management. Regulations to complement the Pharmacy Act are urgently needed to provide the Pharmacy Council and Drug Inspector with guidelines for monitoring the sector; without the passage of these regulations, the strict enforcement of the Pharmacy Act is in some cases interfering with routine service provision. For example, the regulations specify that, despite Pharmacy Act provisions, nurses at the Mental Health Rehabilitation Center pharmacy can dispense pharmaceuticals directly to patients without registered pharmacists in certain circumstances, giving needed flexibility for patients in the mental health community. These regulations have not been implemented yet. Stock-outs of common items like aspirin and antidiabetic medications are reportedly common. To address these issues, the government of Saint Vincent should consider several interventions, such as pushing forward the development and passage of relevant guidelines and regulations and collaborating with the private sector to reduce the burden on public sector mechanisms and ensure consistent availability of pharmaceuticals.

Key findings and recommendations in the area of pharmaceuticals and medical supplies are as follows:

Findings	Recommendations
<ul style="list-style-type: none">Affordable pharmaceuticals are available due to discount bulk-buying through the Pharmaceutical Procurement Service (PPS)Recent investments in pharmacovigilance, lab strengthening, and the creation of an Essential Medicines List are improving the management of pharmaceuticals and medical suppliesLegislation for the pharmacy sector is in place but lacks an enforcement mechanism, namely regulations to the Pharmacy ActAccess to medications for mental health patients attending community-based clinics has decreased, as nurses may no longer dispense in accordance with the Pharmacy ActLimited training on antiretrovirals (ARVs) for pharmacists at the MCMH has resulted in inappropriate medications being prescribed to PLHIVStock-outs (particularly aspirin, antidiabetics, injectable medications, and standard consumables such as latex gloves) are common at multiple levels and have been attributed to cash flow problems impeding procurements, poor inventory management in the districts, and wastage of medications in the hospital wards	<ul style="list-style-type: none">Develop standard treatment guidelines to promote standardized, quality care and more cost-effective treatmentsTrain pharmacists in ARV dispensing to ensure PLHIV are adhering appropriately to their regimenHire more pharmacy students to assist district pharmacists with inventory management to avoid stock-outs at health clinics and district hospitalsRequest immediate fast-tracking of the review of the Pharmacy Act Regulations and assist in finding ways to address personnel issues in the Attorney General's office to complete the reviewsInitiate dialogue between the Pharmacy Association and mental health professionals to reach a compromise on dispensing of medications at mental health clinics by non pharmacistsIncrease budgetary control for Central Medical Stores (CMS) and labsCollaborate with the private sector to supplement the Essential Medicines List with brand-name medications that the private sector, unlike the public sector, may be able and willing to sellAdvocate for a clinical pharmacist position

Health Information Systems

The functioning of the HIS at the national level provides a strong indicator of the overall health systems functioning. The HIS in Saint Vincent today is in transition from a paper-based data capture and reporting at the facility and district level, to a web-based electronic health management information system (HMIS) (known as the SVGHIS) with patient record-level data capture accessible across all public health facilities in the country. This transition has the potential to drastically improve the availability of clinical and epidemiological information, but also has the potential to overwhelm the limited Health Planning and Information Unit (HPIU) staff managing the software customization, personnel training, system implementation, and technical support for the SVGHIS. The private sector voluntarily reports syndromic surveillance data to the MOHE, but not based on any formal requirements on notifiable conditions or other national policies. HIV/AIDS data is systematically reported as is routine health data from primary health facilities. Major bottlenecks exist in compiling and distributing data at the central level. This assessment recommends leveraging the electronic SVGHIS being rolled out, while exploring other technologies (such as mobile phones) for reporting small, routine health data sets.

Key findings and recommendations in the area of HIS are as follows:

Findings	Recommendations
<ul style="list-style-type: none"> • Portions of the electronic SVGHIS system have been rolled out to 70 percent of the public health facilities • Good technical infrastructure (i.e., networks, computers, secure buildings) in place across health facilities to support SVGHIS • HPIU is understaffed to support the needs of a nationally implemented SVGHIS in the long term • Absence of single patient identifier nationally (across all programs, not just health) limits capacity of SVGHIS to uniquely track patients • Data quality is not currently tracked • Feedback loop for HPIU to share and discuss data with primary health facilities is not consistently practiced 	<ul style="list-style-type: none"> • Leverage the E-Government Regional Integration Project (E-GRIP) work plans and team to move the dialogue on national identifiers forward • Pool technical resources with neighboring island (Saint Lucia) staff to share best practices and lessons learned on SVGHIS (based on utilization of the same platform) • Leverage the SVGHIS to engage the private health sector • Explore opportunities to pilot and test telemedicine programs within the Grenadines before initiating robust links with external partners • Implement the Routine Data Quality Assessment (RDQA) Tool across the system • Build upon the electronic reporting platform to explore electronic reporting of syndromic surveillance data • Develop formal staffing plan to support the SVGHIS in the long term

Private Sector Contributions to Health

The private health sector in Saint Vincent has growing potential to contribute to public health goals and health systems strengthening. Currently, it serves an estimated 40 percent of citizens from all socio-economic groups in Saint Vincent, with more than 25 physicians, 13 pharmacies, 4 laboratories, 5 nursing homes, and 15 dentists, as well as nurses and other health service providers. Additionally, a large number of physicians work in both the public and private sectors (known as dual practice). Like many countries in the Caribbean, the government of Saint Vincent is facing domestic budget constraints, growth in chronic NCDs, and declining donor funding for HIV. The private health sector in Saint Vincent remains relatively unregulated and not well integrated with the public health system. There is, however, informal collaboration between sectors, and the developing partnership between the MOHE, the Mustique Company, and the World Pediatric Project has the potential to mobilize significant resources to build a wing for pediatric surgery, expanding access for citizens in Saint Vincent and the region. However, while there is some collaboration between the sectors in Saint Vincent, the public sector could do more to leverage this potential; the MOHE may want to consider engaging private sector entities to relieve constraints in delivering essential health services and possibly realize increased efficiencies in management and resource utilization, a broader market for health promotion messages, and greater responsiveness to consumer preferences. Overall those operating in the private sector were open to and interested in engaging with the MOHE, in order to meet the nation's health needs and also as a way to enhance their businesses. This assessment identified some innovative ways to increase access to specialists and services through private sector engagement that could strengthen the overall health system.

Key findings and recommendations in the area of private sector contributions to health are as follows:

Findings	Recommendations
<ul style="list-style-type: none"> A diverse private medical sector serves an estimated 40 percent of Saint Vincent citizens. Limited data suggest that all socioeconomic classes access private sector health services. The corporate sector has supported and informally partnered with the MOHE for a number of notable efforts in health education and wellness, support services, environmental health, and HIV prevention The World Pediatric Project is a significant public-private partnership for Saint Vincent. The activity has the potential to mobilize significant resources to create a regional pediatric surgical wing to house foreign medical missions for regional surgery, with direct and indirect contributions from the MOHE Weak professional organization and lack of sufficient regulation and quality assurance undermine private medical practice. This includes a loosely regulated dual practice among physicians. With no formal mechanism for engagement, the potential for fruitful collaboration between public and private health sectors is limited. 	<ul style="list-style-type: none"> Conduct a baseline mapping of private sector services and resources as a foundation for increased engagement Review and clarify existing and pending legislation for medical service registration and regulation of private sector physicians and services Initiate dialogue between public and private sectors to identify collaboration opportunities and to develop longer-term plans and health strategies Coordinate health promotion and wellness activities with industry, workplace, and NGO programs Explore partnerships with the private sector that maximize resources for both public and private sectors Identify services in the private sector that may be able to fill gaps in public provision through negotiated contracts Develop and enforce guidelines on dual practice in the public and private sector Engage key private sector leaders in the development of strategic public health plans Review and enact the specific requirements and process for enforcing legislation. Expand health promotion and wellness activities with industry, workplace, and NGO programs Develop and advance opportunities for the private sector to utilize unused capacity at MCMH, or to grow specialty practice with support from the public sector

The Strategic Plan for Health laid out many key strategies to strengthen the Vincentian health system. These strategies included: development of additional polyclinics; updating and implementing key health legislation and regulations to support the regulatory framework; harmonizing health services across public and private health sectors; building a robust electronic HIS; and implementing NHA as a step toward promoting rational allocation and utilization of funds to improve health access and outcomes.

This assessment report, along with the subsequent workshop to validate its findings and prioritize recommendations, is intended to reinvigorate the drive toward achieving those strategic objectives, while leveraging both internal and external support to push key activities to completion. It is also intended to serve as a reference source for stakeholders and researchers. The Validation and Prioritization Workshop was held February 29–March 1, 2012, in Kingstown, Saint Vincent. A report documenting the discussions and outputs of the workshop as well as the feedback and updates from participants can be found in Annex A of this assessment report.

I. ASSESSMENT METHODOLOGY

I.1 FRAMEWORK FOR THE HEALTH SYSTEM AND PRIVATE SECTOR ASSESSMENT APPROACH

Health Systems 20/20 and Strengthening Health Outcomes through the Private Sector (SHOPS), in collaboration with the Ministry of Health, Wellness and the Environment (MOHE), used a combination of the Health Systems Assessment (HSA) and Private Sector Assessment (PSA) approaches to undertake a rapid assessment of the health system of Saint Vincent and the Grenadines. The HSA approach was adapted from the U.S. Agency for International Development (USAID) *Health Systems Assessment Approach: A How-To Manual* (Islam 2007), which has been used in 23 countries. The HSA approach is based on the World Health Organization (WHO) health systems framework of six building blocks (WHO 2007). The standard PSA approach has been used in 20 countries and SHOPS is currently developing a how-to guide for future assessments.

The integrated approach used in Saint Vincent and the Grenadines covered the six health systems building blocks: health financing, management of pharmaceuticals and medical supplies, governance, health information systems (HIS), human resources for health (HRH), and service delivery. Special emphasis was placed on the current and potential role of the private sector within and across each health system building block. Additionally, the health system's ability to support the HIV response was examined throughout each dimension.

The objectives of the assessment were to:

- Understand key constraints in the health systems and prioritize areas needing attention
- Identify opportunities for technical assistance to strengthen the health systems and private sector engagement to sustain the response to HIV
- Promote collaboration across public and private sectors
- Provide a road map for local, regional, and international partners to coordinate technical assistance

I.2 HEALTH SYSTEM AND PRIVATE SECTOR ASSESSMENT PROCESS

I.2.1 PHASE I: PREPARE FOR THE ASSESSMENT

During the preparation phase, the assessment team worked with the MOHE and the National AIDS Program (NAP) to build consensus on the scope, methodological approach, data requirements, expected results, and timing of the assessment. Recognizing the importance of building strong partnerships among the government, donors, private sector, and nongovernmental and community organizations, team members held a pre-assessment workshop in conjunction with the MOHE to meet with stakeholders. The objectives of the half-day workshop were to (1) explain the methodology to be used, (2) identify key issues for further investigation during data collection, and (3) clarify expectations for the assessment.

A team of technical specialists for priority areas identified in the stakeholder meeting was assembled. These priority areas included health financing, governance, and HIS. The team of seven consisted of representatives from Health Systems 20/20, SHOPS, the International Training and Education Center for Health (I-TECH), and the Pan American Health Organization (PAHO).

I.2.2 PHASE 2: CONDUCT THE ASSESSMENT

The majority of health systems data was collected through a review of published and unpublished materials made available to the team by the MOHE and development partners and obtained online. Team members produced a literature review for each of the health systems building blocks to develop an initial understanding of the system and identify information gaps. Semi-structured interview guides were developed for each building block based on the noted information gaps, standard PSA interview guides, and the indicators outlined in the HSA approach. The NAP assisted the team in preparing a preliminary list of key informants and documents for the assessment process. A local logistics coordinator assisted in further identifying potential interviewees and arranging interviews.

Key stakeholders in both the public and private sector were invited to participate in key informant interviews to provide input and validate what has been collected through secondary sources. Interviewees also provided additional key documents and referred the team to other important stakeholders. During the one-week data collection period (July 31–August 5, 2011), the in-country assessment team interviewed 93 stakeholders. Interviewees included representatives of government, professional associations, health training institutions, nongovernmental organizations (NGOs), private businesses, health providers, pharmacists, and many professionals from the MOHE. Site visits on the islands of Saint Vincent and the Grenadines were conducted to verify data from key informants. These visits included public hospitals and health centers, private providers' offices, private labs, and private pharmacies. Responses were documented by the interviewers and examined for identification of common themes across stakeholders while in-country. The team presented a preliminary overview of the emerging findings and recommendations to the MOHE prior to the team's departure.

I.2.3 PHASE 3: ANALYZE DATA AND PREPARE THE DRAFT REPORT

Following the in-country data collection, the assessment team summarized the responses of the stakeholders and reviewed the additional documents collected. The technical lead for each building block and the private sector drafted a summary of the findings and recommendations for their respective areas. The team lead, together with input from the rest of the team, identified key findings and cross-cutting issues and further developed recommendations. The results were compiled in an initial draft and submitted to quality advisors in the Health Systems 20/20 project and USAID for review. To reflect the special focus on HIV/AIDS in this assessment, a brief synthesizing HIV/AIDS-related findings and recommendations across the building blocks was also drafted and reviewed. A final draft was submitted to the MOHE for review and approval.

I.2.4 PHASE 4: DISCUSS FINDINGS WITH LOCAL STAKEHOLDERS

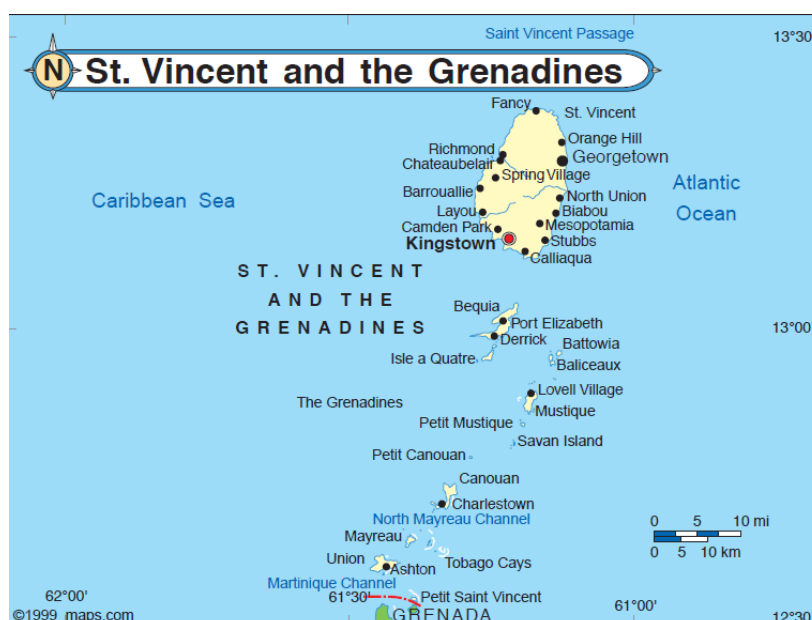
The assessment team used the findings in this draft report to conduct a workshop at which the MOHE and key local stakeholders discussed and validated assessment findings and prioritized the recommendations. Special emphasis was placed on looking at the strengths and weaknesses of the health system across public and private domains and the recommendations to strengthen it and the role of the private sector. The team used the results of the prioritization to identify areas of technical assistance for USAID. A report documenting the workshop discussions and results can be found in Annex A. Additionally, the brief on HIV/AIDS issues in Saint Vincent can be found in Annex B.

2. COUNTRY BACKGROUND AND HEALTH SYSTEMS PROFILE

2.1 OVERVIEW OF SAINT VINCENT AND THE GRENADINES

Saint Vincent and the Grenadines is a multi-island state in the Windward Island chain of the Lesser Antilles. It consists of 32 islands, inlets, and cays, but only 7 of these beyond the main island of Saint Vincent are inhabited (Bequia, Canouan, Mayreau, Union, Mustique, Palm Island, and Petit Saint Vincent). The main island of Saint Vincent is the largest island in size at 340 square kilometers and in population with over 90 percent of the population. The islands are connected by sea ferries and air charters through four Grenadine airports. The country is divided into six administrative units, or parishes: Charlotte, Grenadines, Saint Andrew, Saint David, Saint George, and Saint Patrick. Five of these parishes are located on the island of Saint Vincent. Kingstown, located in the Saint George Parish on Saint Vincent Island, is the capital of the country and largest urban center.

FIGURE 2.1: MAP AND PARISHES OF SAINT VINCENT AND THE GRENADINES



Parish	Main Town	Population (2001 Census)
Saint Patrick	Barrouallie	12,242
Saint George	Kingstown	49,590
Saint David	Chateaubelair	6,081
Saint Andrew	Layou	6,338
Charlotte	Georgetown	25,535
Grenadines	Port Elizabeth	9,236

2.1.1 DEMOGRAPHICS AND POPULATION DYNAMICS

More than 60 percent of the population in Saint Vincent is of African descent from the slave trade. An additional 19 percent of the population is mixed, largely a result of an influx of Indian indentured servants and Portuguese immigrants who filled the labor shortage after slavery ended (Kairi Consultants Limited 2009). The national language is English and some French patois is spoken.

In 2009, the estimated population of Saint Vincent was 109,269 (World Bank 2011a). According to the Saint Vincent 2001 Housing and Population Census, 24.2 percent of the population lived in and around the capital, Kingstown, in 2011 (Government of St. Vincent and the Grenadines [GOSVG] 2001). Since then, the urban population has increased by 2 percentage points (World Bank 2011a). New urbanites have shifted not only towards Kingstown, but also to urban centers in the Grenadines where expanding tourism has created work opportunities (Kairi Consultants Limited 2009). Even so, the urban population in Saint Vincent, at 47.4 percent of the total population in 2009, is smaller than the Latin America and the Caribbean (LAC) average of 78.9 percent, indicating that urbanization is likely to continue (World Bank 2011a).

Urbanization and informal living settlements have caused concern about the health of migrants, or squatters (MOHE 2007). These squatters, numbering nearly 16,000, or 15 percent of the population in 2007, move to overcrowded communities on publicly-owned land at the outskirts of cities and are often engaged in subsistence farming (PAHO 2007). Squatters account for only a small percentage of the population below the poverty line in Saint Vincent: 2007/08 estimates show that approximately 30 percent of the Saint Vincent population lives below the national poverty line (estimated at EC\$5,523 annually) (Kairi Consultants Limited 2009).

Saint Vincent, like the rest of the countries of the Organization of Eastern Caribbean States (OECS), is experiencing an increase in elderly population and a decline in the fertility rate. This shift is largely the result of long-term successes in increasing access to care and treatment for infectious disease (MOHE 2007). The aging population contributes to the increased burden of chronic diseases.

TABLE 2.1: DEMOGRAPHIC INDICATORS IN SAINT VINCENT COMPARED WITH THE LATIN AMERICA AND THE CARIBBEAN REGIONAL AVERAGE FOR DEVELOPING NATIONS

Health System Indicator	Saint Vincent	Year of Data	LAC Average	Year of Data
Population, total	109,269	2009	19,520,385	2008
Population growth (annual %)	1.1	2009	1.1	2009
Urban population (% of total)	47.4	2009	78.9	2009
Population ages 0–14 (% of total)	26.90	2009	28.09	2009
Population ages 65 and above (% of total)	6.78	2009	6.77	2009

Source: World Bank (2011a)

2.1.2 MORTALITY AND MORBIDITY

Life expectancy for Vincentians averages 72 years of age overall, 74 for females and 70 for males. Chronic noncommunicable diseases (NCDs) account for 70 percent of visits to outpatient services and are among the top five causes of death (Gillespie and Neilsen 2010). In 2004 the top five cause of death, in rank order, were diabetes, malignant neoplasms, cerebrovascular disease, heart disease, and hypertension (MOHE 2007). HIV ranked as the sixth-highest principle cause of death that year.

TABLE 2.2: MORTALITY INDICATORS IN SAINT VINCENT COMPARED WITH THE LATIN AMERICA AND THE CARIBBEAN REGIONAL AVERAGE

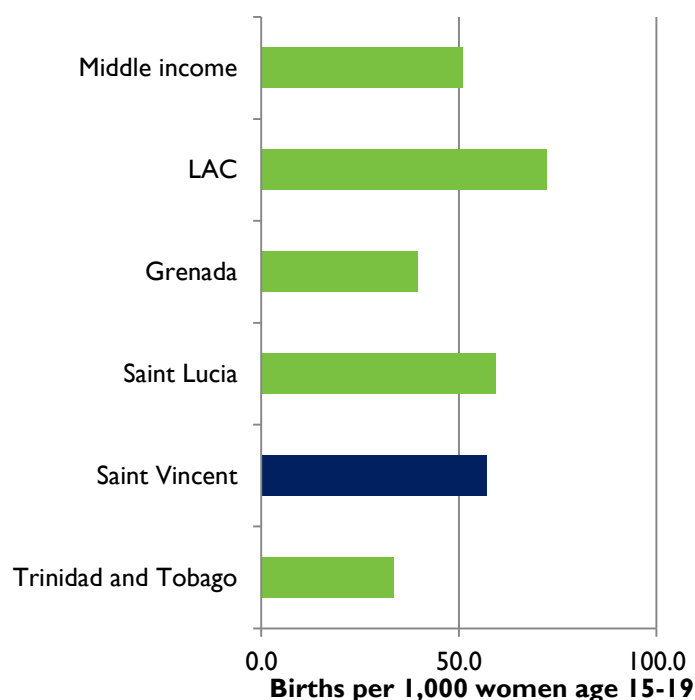
Health System Indicator	Saint Vincent	Year of Data	LAC Average	Year of Data
Life expectancy at birth, total (years)	71.86	2009	73.59	2009
Mortality rate, infant (per 1,000 live births)	11.20	2009	18.92	2009
Mortality rate under-5 (per 1,000 births)	12.40	2009	22.55	2009
Maternal mortality ratio (per 100,000 live births)	93.00	2000	103.46	2008

Source: World Bank (2011a)

2.1.3 REPRODUCTIVE HEALTH AND HIV

Fertility rates have declined from 3.0 births per woman in 1990 to 2.1 in 2009 (WHO 2011a), and women have growing independent control over their choices in health. However, gender inequality continues to exist (MOHE 2007). The 2007/08 Country Poverty Assessment report suggests that the gender inequity is notable because women, who experience more poverty than males, become willing to engage in riskier behaviors, including transactional sex, to provide for their families (Kairi Consultants Limited 2009). The inequality also places women in vulnerable positions that affect their sexual and reproductive health, including abuse, rape, teen pregnancy, and the inability to make choices about their reproductive health (Kairi Consultants Limited 2009; MOHE 2007). Since 2000, women have reported more rapes in Saint Vincent than anywhere else in the OECS (Chance 2011a). Teen pregnancies account for nearly 20 percent of pregnancies (MOHE 2007; Gillespie and Neilsen 2010) and nearly 50 percent of women have their first child between the ages of 15–19 (Kairi Consultants Limited 2009). Negative health outcomes such as anemia, depression, HIV, sexually transmitted infections (STIs), and postpartum hemorrhaging are commonly associated with pregnancy during adolescence (WHO 2008a). Adolescent fertility rates in Saint Vincent, estimated at 57.0 births per 1,000 women age 15–19 in 2009, rank higher than several other Caribbean countries such as Trinidad and Tobago (33.5) and Grenada (39.6), but below the LAC average (72.3) and on par with the average for middle income countries (51.0). Figure 2.2 shows this comparison.

FIGURE 2.2: ADOLESCENT FERTILITY RATES IN SAINT VINCENT COMPARED WITH OTHER COUNTRIES, THE LATIN AMERICA AND THE CARIBBEAN REGION, AND MIDDLE-INCOME COUNTRIES



Source: World Bank (2011a)

Despite the gender inequality, more women in Saint Vincent are using contraception than in past years, which the MOHE has attributed to increased urban migration and the increased presence of family planning initiatives (MOHE 2007). Most women who use a family planning method use oral contraception, followed closely by injectable contraceptives which can be purchased over-the-counter in pharmacies and through private providers like Planned Parenthood (MOHE 2007).

TABLE 2.3: REPRODUCTIVE HEALTH INDICATORS IN SAINT VINCENT COMPARED WITH THE LATIN AMERICA AND THE CARIBBEAN REGIONAL AVERAGE

Health System Indicator	Saint Vincent	Year of Data	LAC Average	Year of Data
Contraceptive prevalence (% of women ages 15–49)*	48.00	2006	74.71	2009
Fertility rate, total (births per woman)*	2.102	2009	2.188	2009
Pregnant women who received 1+ antenatal care visits (%)**	99.50	2008	95.01	2009

Source: *World Bank (2011a), ** UNICEF (2010)

Based on data from antenatal care (ANC) clients, HIV prevalence is estimated to be around 1 percent of the population. The main source of transmission is heterosexual contact (GOSVG 2010a). Since 2008, the HIV program has been undergoing a process of integration with pre-existing programs at the MOHE. In 2009, approximately 89 percent of eligible people living with HIV (PLHIV) (162 persons) were on antiretrovirals (ARVs); an additional 20 people on ARVs accessed care in the private sector (GOSVG 2010a).

2.2 POLITICAL AND MACROECONOMIC ENVIRONMENT

Saint Vincent was the last of the countries in the Windward Island chain to become independent from Great Britain. The country gained independence in 1970 through referendum. Saint Vincent has a democratic constitutional monarchy with a unicameral parliament, the House of Assembly (Commonwealth Local Government Forum 2011). Officially, Queen Elizabeth II is the head of state and appoints, with consultation of the government, a representative to the position of Governor General. A 2009 referendum to replace the monarch with a president did not pass. The House of Assembly has 21 representatives, of whom 15 are elected and 6 are appointed by the Governor General. Of the six appointed representatives, four come through recommendations from the Prime Minister and two through recommendations from the opposition.

The Prime Minister is also appointed by the Governor General, with selection based on the extent of support for candidates among the majority of representatives in the Assembly (United Nations [UN] 2004). The last elections were held in 2010 and the next parliamentary elections should take place in 2015. The Unity Labour Party, which has held power since 2001, won 8 of 15 seats and is represented by Prime Minister Ralph Gonsalves. The main opposition party, the New Democratic Party, won seven parliamentary seats (U.S. Department of State 2011). There is no local government. Local government was dissolved in 1973 and the six parishes are now considered administrative units of the central government for a limited number of services (Commonwealth Local Government Forum 2011).

Indicators on human development in Saint Vincent present a mixed picture. On the one hand, Saint Vincent has been politically stable and the level of income inequality in Saint Vincent is not as serious as elsewhere in the Caribbean. The relatively low income inequality is evident through a comparison of the Saint Vincent Gini coefficient (40.2) to the average Gini coefficient for the LAC (51.3). Also, the literacy rate in Saint Vincent was 88.1 percent of the population over age 15 in 2004 (PAHO 2007). On the other hand, Saint Vincent was only ranked medium on the Human Development Index in 2007 and was behind its Caribbean counterparts in 2008 (UN Development Program [UNDP] 2011). (This indicator was taken out of the 2010 index due to a lack of reliable data.) The index considers the extent to which citizens in a country can achieve their goals and access basic freedoms, and looks at factors such as health, education, and poverty that contribute to a nation's development alongside macro-level indicators. The index then places countries in one of five categories, with medium being second to lowest.

Saint Vincent has a market economy and is a member of two important regional bodies: the Caribbean Community (CARICOM) and OECS. These entities play a vital role in developing policy (including health policy) and are often the recipients of resources or assistance on behalf of the region. Through their economic union, the members of the OECS share a common currency, the Eastern Caribbean Dollar (EC\$). The currency is pegged at EC\$2.7 for US\$1.0.

Table 2.4 presents several macroeconomic and health indicators for Saint Vincent and the LAC region. Saint Vincent has had negative economic growth in recent years, though it generally experienced rising economic growth before the global recession. Between 2000 and 2009, gross domestic product (GDP) growth in Saint Vincent averaged 3.6 percent per annum, but in 2009 declined to -2.8 percent (World Bank 2011a). The decline in GDP was shared across the LAC region, which grew, on average by -2 percent in 2009. The negative growth rate along with the trade deficit makes it hard for Saint Vincent to

address its growing debt burden. Total public debt in Saint Vincent, estimated at 66.8 percent of GDP at the end of 2008, is lower than in any other country in the OECS, but is still notably high (IMF 2009).

Saint Vincent's GDP per capita and per capita expenditure on health fall below regional averages, as shown in table 2.4. These indicators reflect the fact that Saint Vincent has the lowest GDP in the OECS (European Commission Development and Cooperation 2008). The 2007/08 Country Poverty Assessment report found that over 30 percent of the population lived in poverty, with less than EC\$5,523 (US\$2,045) per year in income (Kairi Consultants Limited 2009). The Georgetown and Sandy Bay areas of the main island had the highest incidence of poverty at 55 percent. The report also found that unemployment was 19 percent nationally and 25 percent among the poor. Lack of work has spurred emigration and 36.7 percent of the population in 2010 had emigrated; this indicator places Saint Vincent 14th-highest in emigration rate in the world (World Bank 2011b). Five of the other OECS countries also were highly rated on this list of countries exhibiting strong emigration: Grenada was third, Saint Kitts and Nevis was fourth, Antigua and Barbuda was seventh, and Saint Lucia was 22nd. Given the large population of Vincentians living abroad, it is not surprising that remittances also play a large role in the economy, making up 5.5 percent of GDP in 2007 (Gonsalves 2009).

TABLE 2.4: ECONOMIC INDICATORS IN SAINT VINCENT COMPARED WITH THE LAC REGIONAL AVERAGE

Health System Indicator	Saint Vincent	Year of Data	LAC Average	Year of Data
GDP per capita (constant 2000 US\$)*	4,314	2009	4,823	2009
GDP growth (annual %)*	-2.76	2009	-2.00	2009
Per capita expenditure on health (current US\$)*	301	2009	545	2009
Gini coefficient	40.2**	2007/08	51.3*	2007

Source: *World Bank (2011a), **Kairi Consultants Limited (2009)

The economy is largely dependent on agriculture, tourism, and construction which all vary by season. Banana production employs about 60 percent of the workforce and accounts for 50 percent of exports (U.S. Department of State 2011). Dependence on one crop has made the economy vulnerable to price fluctuations. The reduction in preferential treatment in trade, particularly by the European Union (EU), has negatively impacted the agricultural economy. Saint Vincent is also the world's largest producer of arrowroot (Caribbean Center for Development Administration [CARICAD] 2006), and has become the largest producer of marijuana in the eastern Caribbean, the rise of which has correlated with the decrease in banana production (U.S. Department of State 2011). In an effort to diversify the economy, tourism has become increasingly important. Compared to most other Caribbean countries, Saint Vincent's tourism sector developed rather slowly (CARICAD 2006). Tourism has become particularly important in the Grenadines where luxury resorts have flourished. Tourism is expected to contribute to 7.1 percent of GDP in 2011 and directly employ 3,000 Vincentians, or 6.7 percent of the workforce (World Travel and Tourism Council [WTTC] 2011). The EU has funded infrastructure projects aimed at expansion of the tourism sector.

2.3 BUSINESS ENVIRONMENT AND INVESTMENT CLIMATE

Saint Vincent is considered to be both an upper-middle-income country and a small-island developing state by the World Bank. Like other small-island developing states, Saint Vincent is isolated, lacks economies of scale, has high transportation costs, and is susceptible to natural disasters including volcanic eruptions and hurricanes. All of these factors make Saint Vincent economically vulnerable.

The Heritage Foundation ranks Saint Vincent the 50th freest on its 2011 Economic Freedom Scale. Tourism is the main draw for foreign investment. Flexible labor regulations and macroeconomic stability attract investors, private enterprises are not hindered by government interference, and investment procedures have become more streamlined. By contrast, high public debt and an underdeveloped financial sector constrain growth. For example, the high level of public debt, capturing nearly a quarter of the government's revenue, limits government spending and fiscal policy options, such as covering access to health services.

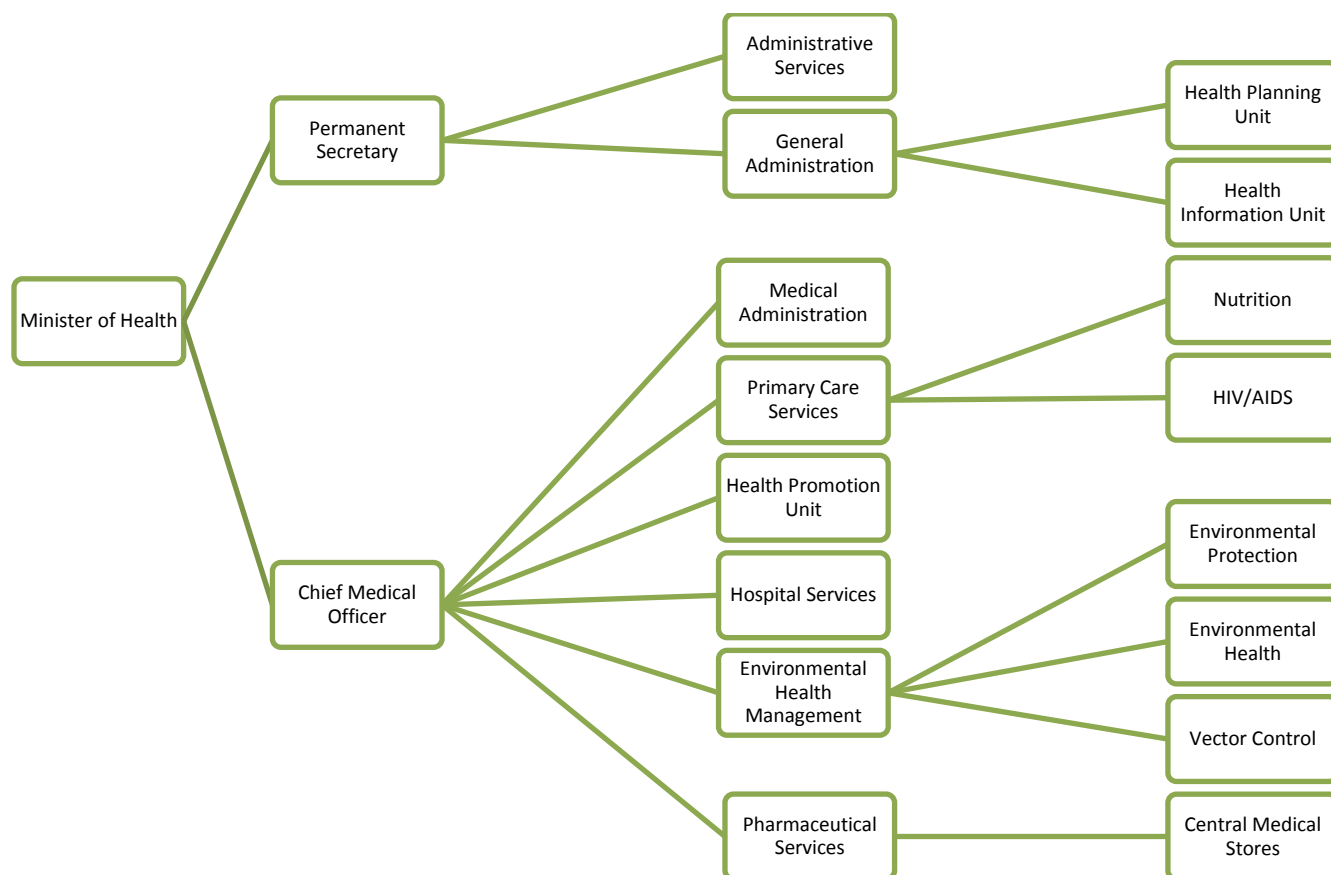
Currently the government is promoting high-end and sports tourism (e.g., becoming a popular set location for films), airport development, financial services, and information technology. There are investment incentives available for manufacturing including duty concessions and tax holidays (InvestSVG 2011). Saint Vincent benefits from the Caribbean Basin Initiative which allows goods to enter the US duty free, and is also a member of ALBA, a Venezuelan-led trade alliance, and CARICOM.

2.4 HEALTH SYSTEM STRUCTURES

The health sector has undergone a series of reforms over the last couple of decades to respond to the changing epidemiological profile and the aging population. The reforms included introducing or increasing user fees for health services and pharmaceuticals, improving nursing education and hospital governance, and studying the feasibility of a national health insurance (NHI) plan. The reform process is ongoing.

The MOHE is the executive arm of government with responsibility for health and environmental policies and service delivery. The Minister of Health, Wellness and the Environment is the political directorate, while the administrative leader is the Permanent Secretary, and the Chief Medical Officer (CMO) is the technical head. There is a Senior Management Committee composed of senior administrative and technical personnel at the MOHE whose primary responsibility is policy development and implementation. The Health Planner is responsible for strategic planning and implementation of the Public Sector Investment Program. Figure 2.3 depicts the MOHE structure by area.

FIGURE 2.3: ORGANIZATIONAL STRUCTURE OF THE MINISTRY OF HEALTH, WELLNESS AND THE ENVIRONMENT, 2011



Source: Adapted from PAHO (2010a) and interviews

An evaluation of the Essential Public Health Functions, a standardized methodology for analyzing public health systems, was conducted by PAHO in 2002. The results showed that monitoring and evaluation (M&E), ensuring quality, and population-based sources and research were the three weakest areas of the system. Two of the stronger areas were the handling of emergencies and disasters and promoting equitable access to care. The upcoming Household Nutrition, Health and Diseases Survey planned for implementation with support from the EU is expected to address some of the need for population-based data sources.

2.5 SERVICE DELIVERY STRUCTURE

Health care service delivery in Saint Vincent is largely provided by the public sector, but the private sector has grown in recent years to complement the limited specialty services and alleviate some of the burden on the public sector. The private commercial sector is not well documented but is known to be concentrated in Kingstown. Data on the division of health services between the public and private sectors are not available. Specialized health services are also concentrated in Kingstown. NGOs provide limited care, mostly through service delivery. For example, the Planned Parenthood Association has contributed to providing reproductive health and family planning services; the Red Cross and the Disaster Preparedness Office (now NEMO) have contributed to the management of crisis situations; and the Rotary and the Lions Clubs, the Cancer Society, and the National Diabetic and Hypertensive

Association have all contributed to direct health care delivery through clinics and outreach. Increased collaboration with all partners has been strengthened through the implementation of the HIV program (MOHE 2007). This collaboration includes the increased numbers of civil society organizations (CSOs) and line ministries working with the National AIDS Secretariat (NAS), the creation of a coordinating body for NGOs working in HIV, and the Employers' Federation implementing workplace HIV policies (MOHE 2010b).

Financing for the health sector is provided through the MOHE's portion of the Consolidated Fund, the National Insurance Service (NIS), and private expenditures. Available data on private expenditures are limited. Public health services are primarily covered most through the MOHE budget. Primary care services are free of charge and all other services are highly subsidized. NIS covers the costs of hospital services for its members. Membership is required for all formal sector employees. NIS, a semi-autonomous structure, also makes donations to the health facilities. For example, NIS donated the ultrasound and CT scan at Milton Cato Memorial Hospital (MCMH). Private insurance also exists on the islands but most policies primarily cover off-island tertiary care. Private corporations also have health insurance and workplace wellness programs for their employees.

According to the national Strategic Plan for Health 2007–2012, a priority of the MOHE is to divest and restructure programs to focus more on formulating policy as well as monitoring and evaluating programs and services. Priorities for the health system include improving the management of the health system and promoting preventative care to reduce the burden of chronic disease.

2.5.1 HEALTH FACILITIES

At the primary care level, the public sector is divided into nine Health Districts with 39 health clinics spread throughout the country. On average, each health clinic is equipped to cater to a population of 2,900 with no patient required to travel more than three miles to access care. At the secondary level, MCMH is the country's only governmental acute care referral hospital providing specialist care. Plans are underway to upgrade the Georgetown Hospital to include a state-of-the-art Diagnostic and Renal Dialysis Unit. Five rural district hospitals, with a combined bed capacity of 58, provide a minimum level of secondary care. Maryfield Hospital, the only private hospital on the island, was a 12-bed, private facility operating in Kingstown. However during this assessment, the facility owner stated that it had been closed. The private sector is active at the primary care level with private providers offering generalist and/or obstetric services. Tertiary care is limited on the island in both sectors. The private sector offers more long-term care facilities for the elderly with five facilities, while the one public sector facility primarily serves the impoverished populations. The private sector also offers advanced diagnostics, which are limited in the public sector to the lab at MCMH. Please see Chapter 5, Service Delivery for more information about these facilities and services.

2.5.2 HIV/AIDS SERVICES

The HIV/AIDS unit within the MOHE manages the HIV program. The National AIDS Council and its Secretariat (the NAS), co-chaired by the Prime Minister and the Minister of Health, Wellness and the Environment, provide multisectoral coordination. There are nine nonhealth line ministries that have focal persons appointed to work with NAS and which have HIV work plans. These ministries are: Education, Finance and Economic Planning, Housing, Labor, National Mobilization, National Security, Rural Transformation, Telecommunication, and Tourism. It has been reported, however, that since the end of World Bank funding in 2011 to support HIV programs in Saint Vincent, these line ministries and CSOs have been less actively involved with the HIV program.

A number of CSO partners actively contribute to the national HIV response. Among the most prominent of these CSOs are Planned Parenthood, Population Services International, and the Caribbean HIV/AIDS Alliance (CHAA). A National Network of NGOs was established in 2002 in response to a

perceived need by national NGOs for coordination of HIV activities and now has 15 members. The private sector is also an active player, addressing HIV through the Employers' Federation and developing HIV workplace policies in 16 workplaces supported by the International Labor Organization (ILO). Private clinics also provide treatment to PLHIV.

Treatment and care for HIV in Saint Vincent is centralized and provided at MCMH. These services are almost all entirely free of charge to the patient. The National Strategic Plan for HIV/AIDS 2010–2014 calls for the establishment of three new antiretroviral treatment (ART)-accredited sites in the public sector within the next two years and three more after that. All PLHIV who attend a public clinic for care and treatment are assessed regarding their social, economic, and psychological situation. Financial assistance is provided to those in need through the Ministry of National Mobilization, Social Development, Family, Gender Affairs, Persons with Disabilities and Youth. Priority for financial assistance is given to orphans, the physically impaired, and the elderly. Assistance is provided in various forms, such as school lunches, school supplies, school fees, monthly stipends, and monthly food packages. Travel reimbursements for eligible clients also exist. During interviews conducted for this assessment, PLHIV reported a decrease in these support services (e.g., the receipt of food support packages and monthly stipends) in recent months.

Voluntary counseling and testing (VCT) services are being integrated in primary health care services across the country. The VCT program was started in 2003 but expanded starting in 2006 with increased training for health care workers (often nurses) to provide rapid testing at health clinics on a daily basis (MOHE 2010b). The health clinics have also introduced provider-initiated testing and counseling. Private labs also provide standard HIV testing and rapid testing. By the end of 2007, however, only 30 percent of 15–49 year olds in Saint Vincent had been tested at least once, which was below the pace to meet the National Strategic Plan for HIV/AIDS target for 2009 of 50 percent (MOHE 2010b). One of the biggest challenges to meeting this goal has been human resources. Staff trained in rapid testing often must be deployed to other facilities to fill vacant positions, making it challenging to ensure that each of the 45 facilities in the public health system has trained staff (MOHE 2010b).

2.6 HEALTH SYSTEMS STRENGTHENING CAPACITY

Health system strengthening is important because effective management of the six building block areas and their interactions leads to more equitable and sustained improvement across health services and health outcomes (WHO 2007). The success of health system strengthening (HSS) activities, to some extent, depends on the capacity of the organizations that are aimed at strengthening health systems. Having the ability to effectively deliver health services does not always mean that the capacity for HSS is present. HSS requires that the appropriate enablers, including leadership, research, technical assistance, training, advocacy, and standard setting, are present.

The MOHE does not have financial resources outside of recent investments by the EU that are devoted to HSS alone. The Health Planner has been active in developing plans to use the EU funding for improving the health system; however, she does not have sufficient support staff to carry out HSS activities on a regular basis. Further, data needed to inform HSS and health policy reform, such as cost data, are not regularly collected due to human resources and funding constraints. The MOHE has tried to leverage donor funding and technical assistance from PAHO institutions for health-related research projects that would guide planning for HSS. The implementation of a new electronic health information system should improve the availability of data that can be more easily analyzed. This new capacity will be timely, as much of the manually collected data that is currently collected is not analyzed in a timely manner, and is thus hard to convert into information that can inform the policymaking process.

Professional associations are able to assist in establishing standards for quality of care and professional registration; regional associations also contribute. Regionally, CARICOM and the OECS provide guidelines that the MOHE can follow to promote HSS but they do not often come with the financial and

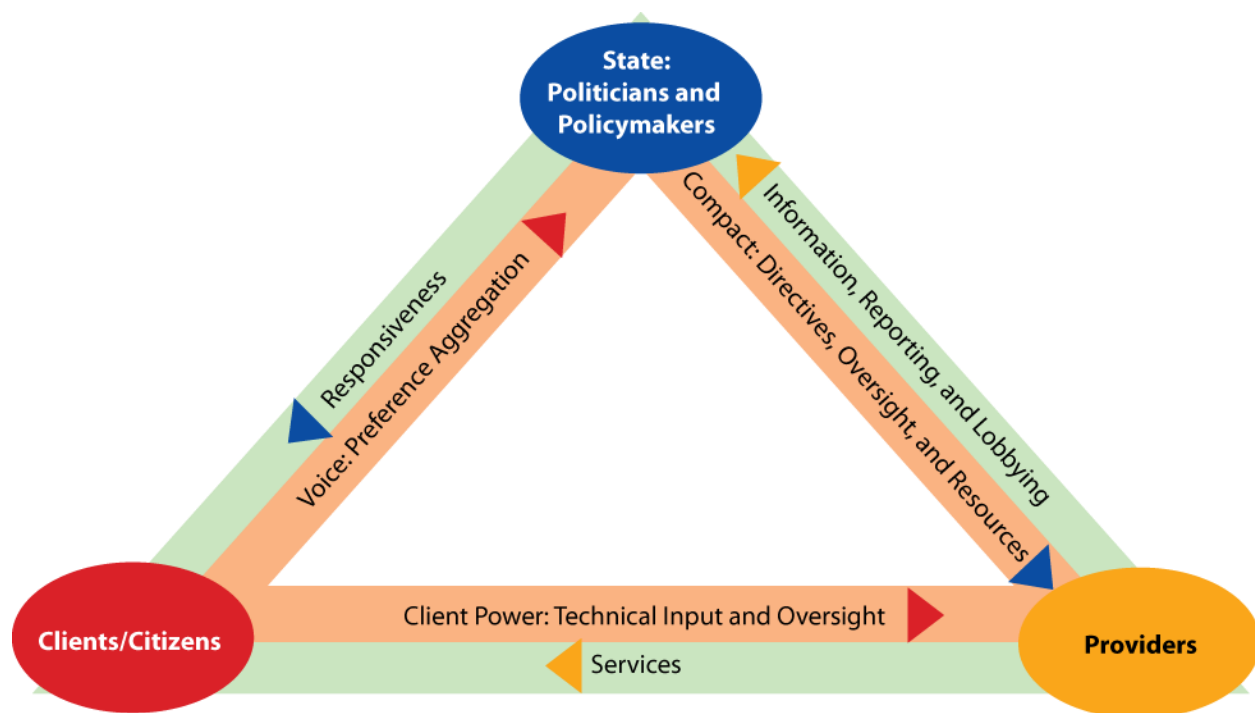
human resources needed to carry out the activities. Saint Vincent does not have an extensive consultant community providing technical assistance when the MOHE lacks the capacity or time to undertake HSS initiatives, and regionally the pool is also somewhat limited. NGOs such as the Diabetic and Hypertensive Association, Planned Parenthood, and CHAA provide strategic partnerships with the MOHE, mostly in service delivery. Training in areas like health economics or health policy does not exist on the island. The Saint Vincent School of Nursing and Trinity University School of Medicine provide opportunities for nursing and medical training, respectively, but those seeking public health degrees need to go off-island. The University of the West Indies, located in Trinidad, does offer these types of courses for the region, but overall, the capacity to provide public health education in the region is very limited.

3. GOVERNANCE

Key Findings

- Citizen engagement with the health system is informal
- Legal framework for the health system is outdated, and does not reflect current issues
- Hospital management structure does not promote accountability, flexibility, and efficiency
- Government transparency is hindered by the absence of a Freedom of Information Act (FOIA)

Effective health governance is the process of competently directing resources, managing performance, and engaging stakeholders toward improving health in ways that are transparent, accountable, equitable, and responsive to the public (USAID et al. 2006). Sustainable health interventions require that all of these elements are in place, as each element is dependent on the success of all of the others. In order to understand how each element functions, Health Systems 20/20 has developed a health governance framework that involves three primary sets of actors that have responsibility for ensuring a strong health system: the state, health providers, and citizens (Brinkerhoff and Bossert 2008).



Source: Brinkerhoff and Bossert (2008)

The roles and linkages between these health system actors constitute the core of the health governance framework. State actors include politicians, policymakers, and other government officials. Together, they develop, implement, and enforce the rules and regulations that govern the health system, provide policy leadership and oversight, organize state-managed insurance schemes, and determine financing for significant parts of the health system. Ideally, state actors are also responsible for responding to citizen voice. Providers are public and private sector health care staff and facilities as well as the organizations that support service provision. Their main role is to deliver services to clients and provide information to politicians and policymakers on performance and health indicators. Citizens are consumers of health services. Citizens' interests in health extend to the societal benefits of health services, not just their impacts on individuals. This assessment seeks to understand how these actors interact in Saint Vincent, how formal and informal structures reinforce or inhibit these linkages, and how the linkages influence the ability of the health system to meet performance criteria.

3.1 OVERVIEW OF GOVERNANCE IN SAINT VINCENT

3.1.1 WORLDWIDE GOVERNANCE INDICATORS

In order to study health governance, it helps to frame the health sector within the larger governance environment. The World Bank Worldwide Governance Indicators (WGIs) are composite indicators that draw on a wide variety of sources to create scores across six different elements of overall governance. The World Bank develops a composite score using data from survey institutes, think tanks, NGOs, and other international organizations. For the most part, these organizations use quantitative and qualitative surveys, such as interviews and document reviews, to develop their scores. These scores are then combined into a composite score. The percentiles show the percent of countries in the world that scored lower than Saint Vincent on the selected indicators. These indicators can be instructive for looking at health governance in Saint Vincent as they give an overall picture of the strength of governance structures.

TABLE 3.1: WORLD BANK WORLDWIDE GOVERNANCE INDICATORS: SAINT VINCENT AND THE GRENADINES

Governance Indicators	1998	2000	2003	2005	2007	2009
Voice and Accountability	78.8	80.3	84.1	82.2	85.6	84.4
Political Stability	82.7	83.2	77.9	93.3	73.6	79.2
Government Effectiveness	53.4	58.3	52.9	80.1	74.9	75.7
Regulatory Quality	60.0	59.0	59.0	78.0	72.8	65.7
Rule of Law	41.4	64.3	66.2	74.3	71.4	75.5
Control of Corruption	60.7	60.2	63.6	82.5	79.2	83.8

Source: Kaufmann et al. (2010)

Country's percentile rank (0–100), 100 is the highest score, 0 the lowest.

The WGIs for Saint Vincent show strong performance on most governance indicators, many of which have shown remarkable improvements since 1998. Government Effectiveness and the Rule of Law, for example, have increased significantly in the past 10 years. Additionally, Control of Corruption has also improved significantly; Saint Vincent is now in the top quintile of all countries in the world on this indicator. The weakest indicator, Regulatory Quality, is a continuing challenge not only for Saint Vincent but for many of the countries in the OECS.

3.1.2 HEALTH GOVERNANCE

The health system in Saint Vincent is guided by the Strategic Plan for Health, which frames the health system in terms of four strategic directions. These directions are:

- Strengthening HIS and the organization and management of HRH
- Promotion and improvement of prevention and management strategies of chronic disease and other priority health needs
- Articulation of policies to promote universal coverage, equity, and sustainability of the health system
- Strengthening the steering role of the MOHE (MOHE 2007)

These strategic directions are outlined in a logical framework, with indicators associated with each direction. These directions address some of the major challenges facing the health system in Saint Vincent, most notably the emergence of chronic diseases as primary causes of morbidity and the need for improved management of the current health system. The methods proposed to achieve the expected outcomes identified in the strategic plan, however, are not clear, especially regarding improving the stewardship role of the MOHE and improving financial sustainability. Additionally, little mention is made of the weak regulatory framework, legislation that is stuck at the Attorney General's office, or methods for improving citizen engagement on health issues.

3.2 POLICY AND REGULATORY ENVIRONMENT

It was recognized in the mid-2000s that there was a need for legislative reform in Saint Vincent. The legislative framework is the basis for the health system, laying out the rules under which all health system actors, the state, providers, and citizens, interact. Legislation contributes to the proper functioning of a health system by ensuring that stakeholders, such as providers, clients, and health managers, understand and follow a set of rules that guide the health system. Revising and updating laws to match changes in the surrounding environment guarantees that the laws match needs, while enforcing these laws through regulatory bodies is critical to ensuring that the laws are followed.

3.2.1 MAJOR HEALTH LEGISLATION

Efforts have been made in the last 10 years to update the laws governing the Saint Vincent health system, but work remains to be done. Even though outdated legislation was noted as a challenge in the Strategic Plan for Health, legal reform does not seem to be a key priority of the MOHE. As a result, many pieces of legislation remain in draft form or have not yet been fully enacted. Only the Pharmacy Act (2002) that came into effect in 2004 has actually come into law. While pharmacists, nurses, and doctors have legislation that govern their roles, provisions for continuing education, re-registration, facility inspection for quality assurance, and formal policies on laws are weak or nonexistent. Additionally, there is no disease-specific national legislation dealing with the rise of chronic NCDs or with specific antidiscrimination issues relating to HIV.

A list of key legislation can be found in Table 3.2. The Public Health Act grants the MOHE broad authority to regulate and enforce health codes in private businesses and homes, including food production and storage, water purification, and mosquito control. The Mental Health Act regulates the conditions under which patients may be voluntarily admitted to the Mental Health Rehabilitation Center and sets up a board to review mental health cases. The act does not include provisions for the rights of mental health patients, accreditation of facilities, or involuntary admission (WHO 2009). The rules for health professionals provide for councils to oversee the registration and practice of medicine, nursing, and pharmacy. No legislation regulates the functioning of the hospital or of the various rural hospitals or

health centers. For a discussion of existing regulatory mechanisms, please see Section 5.4, Quality Assurance in Chapter 5, Service Delivery.

TABLE 3.2: KEY HEALTH LEGISLATION

Legislation	Date Enacted
Public Health Act	1977
Medical Officers Act	1956
Medical Registration Act	1886
Nurses, Midwives, and Nursing Assistants Act	1986
General Nursing Council Rules	1990
Milton Cato Schedule of Fees	1995
Mental Health Act	1958, 1991
Pharmacy Act	2002

The Medical Registration Act of 1886 sets up the regulatory practice for medical care, including the private sector. The act is outdated and does not reflect or cover the other types of medical practices present in Saint Vincent today, such as lab technicians, diagnostic centers, nursing homes, and occupational therapists. Draft legislation based on the CARICOM Act that would update laws governing the establishment of medical service practice was submitted to legal affairs in 2006 but has not been passed. Neither the Medical Officers Act (1956) nor the Medical Registration Act enumerates requirements for continuing medical education (CME), testing, re-registration, or re-licensure. The same is true for the Nurses, Midwives, and Nursing Assistants Act and the General Nursing Council Rules, which govern the nursing profession. The one exception to addressing CME issues is the Pharmacy Act, passed in 2002, which makes provisions for continuing education and re-registration. Though both continuing education and re-registration were supposed to have been implemented in accordance with regulations to the actual Pharmacy Act, these regulations have not yet been passed into law. Most legislation related to health can be found in the Laws of Saint Vincent in force on 1st January, 1991 under Title XVII, Health, Education, and Social Services.

The legislation identified above is enforced by three professional councils: the General Medical Council (covering medical doctors and dentists), the Nursing Council, and the Pharmacy Council. As noted, these councils grant registration but do not issue any certification based on credentials, such as CME, or current practice load. These councils assess annual professional registration fees on registered health workers, but these are not actively enforced.

While the private sector is independent from the government, medical provider ethics dictate and citizen businesses require adherence to the country's laws and the government's regulations which are in place to protect its citizens. Official oversight and regulation of private providers rests with the MOHE (through the CMO). The Medical Registration Act sets up the regulatory practice for medical care, including private physicians. Other medical practitioners and establishments, such as lab technicians, diagnostic centers, nursing homes, and occupational therapists are not included. Due to lack of regulation, a business can be established without proof of credentials for these professions.

In Saint Vincent, the private health sector largely operates independently from the public sector, even though it is partially composed of practitioners from the public sector who are in dual practice. There is little regulation by and no formal engagement with the MOHE. This independence is beneficial for business, but does not ensure that quality health care is delivered to Vincentians. For the most part, the professional councils do not engage in regulation or set quality improvement standards. Some professional councils offer active support and guidance to their members, but mostly they act as registration bodies that validate credentials for doctors, nurses, pharmacists, and dentists.

The lack of effective regulation over private providers was evident in interviews conducted for this assessment. No providers interviewed could recall active regulation enforcement from the MOHE. Several stakeholders interviewed voiced concern about the need to update regulations and the lack of regulation enforcement. A strengthened regulatory practice was viewed by the interviewees as the ability to prohibit and close unethical medical practice and businesses. Several providers acknowledged that it was important to report notifiable diseases to the MOHE (e.g., HIV, tuberculosis, hepatitis, dengue), but that it was not consistently done by all providers, nor was there active follow-up on these issues by the Chief Epidemiology Officer.

3.2.1 CIVIL SOCIETY ENVIRONMENT

Direct access to parliamentary representatives in Saint Vincent appears to fulfill the advocacy role typically played by civil society. A primary reason relates to differences in population: the large number of representatives per citizen in Saint Vincent (109,000 people and 15 elected parliamentary representatives) allows citizens to have greater direct access to policymakers than is the case in larger democracies. Interviewees noted that citizens often go directly to their parliamentary representative, rather than through a civil society intermediary, if they encounter a problem or have a complaint about government services.

With direct access to representatives providing the country with a mechanism for dialogue between citizens and decision makers in Saint Vincent, CSOs tend to focus on other needs. For example, many church-based organizations, such as House of Hope, focus on care and services for PLHIV, while Planned Parenthood procures and distributes contraceptives. While neither of these organizations engages in advocacy for specific health issues or attempts to present citizen feedback to policymakers, they both contribute to strengthening service delivery. A list of CSOs in Saint Vincent is presented in Table 3.3.

TABLE 3.3: SELECTED HEALTH-FOCUSED CIVIL SOCIETY ORGANIZATIONS IN SAINT VINCENT

Organization	Role
House of Hope	Care and support for PLHIV
CHAA	Advocacy and support for PLHIV; technical assistance
Diabetic and Hypertensive Association	Education and prevention through community organizing
SVG Human Rights Association*	Legal assistance and human rights education
Windward Islands Farmers Association	Infrastructure; farmer health issues
SVG Red Cross	Disaster management and HIV prevention
Cancer Society	Financial support for overseas care; cancer education
Planned Parenthood Association	Providing contraceptive methods
Rotary Club	Fundraising for general health and social welfare issues
Lions Club	Fundraising; eye health

*Note: SVG = Saint Vincent and the Grenadines

There are, however, some organizations that do advocate for citizen groups in Saint Vincent. For example, the Human Rights Association and CHAA advocate for the rights of PLHIV in two different, yet complementary ways. CHAA, as a regional organization, focuses on technical assistance for local organizations that support PLHIV and NAS. Through this technical assistance, they promote evidence-based approaches to mitigating the HIV epidemic. The approach of the Saint Vincent Human Rights Association is more aggressive, as they promote the rights of PLHIV through legal action and by challenging policymakers on commitments they have made, especially on greater protections for PLHIV.

The work that CSOs do is made more difficult by the fact that the FOIA, though completed in 2003, has not been signed into law and implemented by the Prime Minister. Without a FOIA, government agencies

are not under any legal obligation to provide citizens or civil society with information. In fact, interviewees noted that many civil servants were unaware that a FOIA even existed. The Human Rights Association has been one of the main voices in support of implementing the FOIA. CSOs that sought to collaborate, rather than challenge the government, appear to be better received. Many organizations noted that they had conducted joint public outreach efforts with the MOHE at health fairs or other gatherings.

Some organizations that would traditionally fall outside of the health sector are still actively engaged in health issues. The Windward Islands Farmers Association (WIFA) is one such organization. As a regional association, WIFA has a presence in Saint Vincent, Saint Lucia, and Dominica. WIFA advocates for tighter integration between the agricultural and health sectors, and works to educate its membership about environmental health issues, as well as HIV and prevention of heart diseases and diabetes. These programs have been funded by members, with collaboration from the MOHE, which sent nurses and education specialists to support the programs when requested.

In addition to traditional citizens groups, health provider associations exist in Saint Vincent for doctors, nurses, and pharmacists. These organizations have varying degrees of strength and involvement in crafting health policy, though all have been active in trying to get new regulations for their respective professions.

These organizations also face challenges because there are so few health professionals in Saint Vincent, (excepting the overabundance of nurses) which leads to instability when key members change or when obtaining a quorum for meetings becomes challenging. Additionally, differences between private and public sector providers, especially around hospital access issues and regulations of dual practice, contribute to associations being unable to reach agreements. Finally, many association members are also MOHE employees, limiting their advocacy role.

3.2.2 PARTICIPATION AND REGULATION OF THE PRIVATE SECTOR

The private sector in Saint Vincent also has active groups, the SVG Medical Association in particular, that are not part of civil society but instead support private practitioners. The association, which includes all doctors and dentists, is primarily a registration body for medical practitioners. The association has promoted medical education and courses to its membership, as well as opportunities to provide services for charitable causes. The association has taken a lead in strengthening medical credentials by promoting ethical standards for care. It has also attempted to engage with the MOHE on policy discussions to address the modern medical sector in Saint Vincent by drafting new legislation to more comprehensively cover medical practice by including a broader range of medical providers (such as radiologists, specialists, and technicians). Given the composition of membership in the association, with both public and private practitioners represented, the association would seem to be ideally placed to facilitate public-private engagement for strengthened health care delivery in Saint Vincent. However, though it appears on the SVG Medical Association website, 2005 draft legislation has not been passed and remains in the Attorney General's office for approval. Also, the SVG Medical Association is not mentioned as a key partner in MOHE strategic documents, and stakeholders interviewed for this assessment did not appear to see it as an important organization.

Other private businesses provide commercial services that potentially influence public health on the island. Examples include the environmental health/pest control services that are experienced in mosquito control; five private nursing homes, which keep doctors on retainer and employ private nurses; private health insurance companies that provide policies for some workers through their employers; and the Trinity Medical School, an offshore private medical school located in Kingstown that provides some continuing education courses to the island's providers and offers lower fees for residents to attend medical school.

Additionally, some organizations that would traditionally fall outside of the health sector are still actively engaged in health issues. The Saint Vincent Employers Federation (SVEF), which represents 50 small and medium enterprises in Saint Vincent, is leading the country's employers in the development of HIV workplace policies. This work has been funded by the regional ILO since 2005 and to date over half of SVEF's member companies have drafted workplace policies.

The Ministry of Tourism collaborated with NAS to carry out workplace training of major tourist operators and hotels for HIV prevention and stigma reduction. These trainings are still in place and are largely funded by the large tour operators. Larger resort companies have developed workplace health and wellness programs that cover HIV prevention and education, programs on healthy eating and exercise, and screenings for diabetes and blood pressure. These efforts support the MOHE's wellness strategy, but they have not been developed with MOHE leadership, nor are they measured for their effectiveness.

There are also numerous examples of private companies making contributions, both charitable and strategic, to the health sector in Saint Vincent. Some examples of charitable programs include the following: Rotary clubs in Bequia have contributed equipment to the local health clinics; the Mustique Charitable Trust equipped the neonatal intensive care unit at MCMH and is funding a pediatric surgeon at MCMH, and along with Rotary, has funded numerous medical missions for pediatric surgery for seven years; a local radio program has provided free air time for 20 years to the MOHE for a health and wellness promotion program; and Scotiabank funds the Bright Futures program which includes health education to youth at risk. An example of a more strategic contribution is that of Trinity School of Medicine, which pays an annual fee to MCMH for the right to collaborate with the hospital for education purposes. The school also provides local public sector doctors with the opportunity to learn from visiting doctors and to lecture and supplement their income. Currently, the Trinity School of Medicine is co-funding a pediatric surgeon with the Mustique Charitable Trust to work at MCMH.

In summary, employers seem active in promoting health, wellness, HIV stigma prevention, and providing other similar services in the workplace. Many companies are eager to make a contribution toward health and wellness for their employees, but are not always aware of the health education needs, gaps in their programs, and opportunities for external collaboration. The MOHE Division of Health Promotion could provide the leadership for these companies to understand the health needs of their populations and link the program with national health and wellness priorities. Collaboration would mutually benefit companies and the MOHE by developing effective corporate health communication platforms to reach Vincentians, without consuming additional MOHE operating resources. For this to happen, the benefits of sharing information and collaborating need to be tangible and mutually understood. Understanding the investment by companies in these programs, as well as their value – whether it be charitable, educational, or strategic – would help establish their value in the eyes of the government, and might lead to a more constructive engagement with the private sector about improving health in the country.

However, business and industry as a whole appear to be absent from the policy dialogue in Saint Vincent. The Saint Vincent and the Grenadines Chamber of Commerce has been invited to be a part of MOHE strategy development, but has not actively participated or attended meetings. The Chamber of Commerce represents the island's broader business interests, composed usually of small and medium enterprises. According to interviews with its current president, the chamber has been fairly weak over the past few years and has not actively engaged on health-related issues.

The exception to engagement on policy seems to have been the discourse related to HIV, especially during the active Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) grant periods. As part of the HIV response in Saint Vincent, line ministries engaged with CSOs and the private sector to address HIV issues under the National Strategic Plan for HIV/AIDS. SVEF collaborated with the Ministry of Labor to draft legislation for occupational safety and against discrimination toward PLHIV in the workplace in 2009. The draft legislation is currently in the Attorney General's office. Apart from the

examples noted here, there does not appear to be an ongoing dialogue with the MOHE to shape and inform health policy.

3.2.3 PROPOSED LEGISLATION

The rise of NCDs as a major health concern has led to increased demand for services and a need to rethink how the legislative framework can promote quality health services. In order to acknowledge these changes, the MOHE has engaged in evaluations of primary health care with PAHO, and has studied the possibility of transitioning the hospital into a statutory body in order to improve management and quality care. The goal of these reviews has been to strengthen the stewardship role of the MOHE, in line with the objectives laid out in the Strategic Plan for Health (MOHE 2007).

In addition to these major changes, the MOHE, in conjunction with various provider associations, has also worked to develop new standards for pharmacists, doctors, nurses, and some auxiliary staff. These efforts were laid out in the Strategic Plan for Health, which called for health legislation and regulations to be reviewed and updated by 2012 without specifying which pieces of legislation needed updating. The MOHE also proposed in the Strategic Plan for Health to develop and enact legislation to protect PLHIV, though none has yet been proposed.

TABLE 3.4: KEY LEGISLATIVE UPDATES

Legislation	Status
Hospital Authority Act	Bill was drafted; the House of Assembly has not yet voted on it
Pharmacy Act Regulations	At the Attorney General's office since 2006
Registration for Nurses, Midwives, and Nursing Assistants	Bill in discussion; will go to Attorney General's office by the end of 2011
Public Health Act	At the Attorney General's office
Mental Health Act	At the Attorney General's office
Medical Act	At the Attorney General's office since 2005
Freedom of Information Act	Bill was passed in the House of Assembly, but requires the Prime Minister's signature

While these various efforts were outlined in the Strategic Plan for Health, the fact remains that very little movement has occurred in improving the regulatory framework. As Table 3.4 shows, there are at least seven important pieces of legislation or regulation that are stuck in various stages of implementation. The reasons for not moving forward with specific pieces of legislation are opaque especially with the Hospital Authority Act and the FOIA. Some interviewees felt that the Hospital Authority Act was being delayed because of the uncertain impact that the bill would have on the hospital employees, especially doctors with private practices. Other bills are thought to be held up because of human resource constraints at the Attorney General's office, though the MOHE can prioritize specific pieces of legislation that it needs to have drafted in an annual request. In addition, pressure from the Minister of Health, or the Prime Minister, can move legislation faster through the drafting process. The proposed legislation in Table 3.4, as drafted, would go a long way toward improving the legal framework in Saint Vincent by encouraging greater transparency, providing stronger regulation for continuing education for medical professionals, and developing health system structures less prone to political risk.

Finally, no HIV-specific legislation, regulation, or policy explicitly protects the rights of PLHIV, provides mechanisms for reducing discrimination in institutional settings, or provides sanctions for government workers who act in a stigmatizing manner, such as breaching confidentiality. Interviewees noted that since there were no specific protections for PLHIV enshrined in legislation, potential VCT clients are fearful that they will be discriminated against if they are found to have HIV.

3.3 GOVERNMENT STRUCTURES

In Saint Vincent, the health system is divided into nine health districts and consists of 39 health centers, 5 rural hospitals, and 1 central referral hospital. On the one hand, recent assessments show that these structures have the capacity to absorb resources and implement programs with measurable improvements against indicators. The August 2011 World Bank assessment of the 2005–2011 HIV/AIDS Prevention and Treatment Program reports that Saint Vincent not only achieved a high execution rate of the World Bank funds for this program, but also made significant progress on several key outcome and intermediate outcome indicators. Though the implementation period was extended, in the end, Saint Vincent received over 90 percent of the funds. (For more information on this assessment, please see Section 5.3.2, Vertical Programs in Chapter 5, Service Delivery.)

However, this assessment also noted deep challenges currently preventing levels of public provision of health care from performing effectively and efficiently. (The roles of these different levels in the public provision of health care are defined in Chapter 5, Service Delivery.) Most importantly, these levels operate with little autonomy: all budgets, human resources, and strategic decisions are developed at the central level. Each health district does have the responsibility to report on service statistics and disease patterns within their catchment areas to Community Health Services. That responsibility includes the ability to make suggestions about areas of need, such as staffing or equipment shortages, but does not confer the ability to make decisions about these items.

The governance structure at MCMH is emblematic of these challenges, as no one person is responsible for the entire hospital. Rather, there are three members of senior management at MCMH that have responsibility for different areas of the hospital. These members are:

- The Medical Director is responsible for medical services and oversees the work of the physicians on staff
- The Senior Nursing Officer is responsible for all nursing services and oversees seven units and three departments; each unit has a ward sister (charge nurse) who oversees the operations within the unit
- The Hospital Administrator is in charge of all administrative and financial functions of the hospital, including oversight of the orderlies, financial management, and maintenance

Division of labor in this manner keeps the hospital from being fully integrated. For example, the 2010–2011 work plans and budgets for the hospital were developed separately and not consolidated into one overarching MCMH plan (Gillespie and Nielsen 2010). As a result, the institution is fragmented: oversight of the hospital rests with the MOHE, human resources decisions are split between the MOHE and the Service Commission Department (SCD), and strategic direction is often exercised by the Cabinet. While this structure does provide the MOHE, and to some extent the Cabinet, with direct oversight of the hospital, it also puts management decisions under institutions with little direct involvement or knowledge about the day-to-day operation of the hospital. As a result, decision makers may not be fully informed about the needs and capabilities of the hospital, which affects the ability of management to promote optimal performance. Performance challenges due to poor integration and decision-making processes are particularly acute in human resources, user fee collection, and capital purchasing.

Managers at the hospital have no autonomy to hire or promote high-performing employees and little recourse to sanction underperforming ones. Sanctions must be routed through the MOHE and the SCD before any action can be taken. The circuitous process means that minor infractions, like tardiness and absenteeism under two days, are often not addressed. Additionally, hospital managers have little authority over the people they supervise; they are limited to tracking attendance, organizing trainings, and providing recommendations to the MOHE or the SCD. Interviewees noted that absenteeism was a recurring problem and that their best recourse was to appeal to an employee's sense of duty.

User fees for services at MCMH, as defined in 1995 legislation, are, in theory, collected at the hospital at the time of service. In practice, many patients request to be billed or fall under one of the groups of people who are exempted from user fees. Though MCMH does have a system of following up by phone with patients who have not paid their bills, interviewees estimated that overall only about 20 percent of all user fees are actually paid due to exemptions and to nonpayment from clients who receive bills by mail. As for the exemptions, some of the problems with implementing user fees concern the number of groups who qualify for exemptions as well as the lack of a nationally standardized policy for exemptions. Groups such as prisoners, youth, senior citizens, police officers, and prison guards qualify for user fee exemptions. At most facilities visited by the assessment team, a paper posted near the front desk or door explained the facility's exemption policy. These policies varied by site. For example, the exemption policy for senior citizens at one facility applied to individuals ages 59 and above while at others it applied to individual 60 or 65 and above. Similarly, "youth" at some facilities is defined as 16 and below while at others it is defined as 18 and below. This degree of variation makes it harder to enforce the 1995 user fee policy. For more information on the MCMH user fees, please see Section 4.4.1, Resource Mobilization in Chapter 4, Health Financing.

Additionally, no system exists to rationalize the purchase of new equipment and determine which services will be offered. Many interviewees noted that the hospital should acquire new equipment, but without determining if the demand exists or if the hospital has the capacity to operate the equipment, it is impossible to know if the new equipment will actually improve health services or drain resources from an already overstretched system. For example, the hospital has recently acquired a CT scan machine. As of the assessment, the scanner was sitting unused and the plan for its use was unclear. Further complicating the use of the CT scan machine is the legislation of user fees, as fees for a CT scan (and other new medical technologies) were not included in the original legislation.

3.4 VOICE AND RESPONSIVENESS

Responsiveness describes how governments answer citizens' and civil society requests, organize structures for citizens to give feedback on health system issues, and make health information publically available.

In interviews with civil society and government, government responsiveness appears to depend on who is requesting information. Organizations that are more technical or focused on collaboration with the public sector have an easier time obtaining information than organizations that advocate for specific viewpoints or challenge the government on specific health issues. The lack of a FOIA hinders the ability of more confrontational CSOs to obtain health system information.

Responsiveness also entails organizing structures for citizens to be heard on health system issues. In Saint Vincent, informal structures exist for exercising voice, such as meetings with representatives and radio call-in shows. These formats offer opportunities for citizens to make their voice heard or get specific types of assistance, but are not very effective at making structural changes to the health system. These informal mechanisms exist partly because there are few formal mechanisms to collect citizen feedback, such as town hall meetings or client-provider forums.

The 2010 MOHE Annual Report, which contains statistics on usage and disease patterns and information on health system assets and challenges, is one avenue to develop stronger responsiveness to civil society and citizens. This annual report will include information on health system utilization, service statistics, the state of physical infrastructure, and challenges that the health system has faced. Strong dissemination of this annual report so that civil society, citizens' groups, and provider organizations have an opportunity to make comments and ask questions should be an integral part of this process.

MCMH has a separate set of challenges in responding to the needs of the public. One aspect of hospital transparency is the existence of a patient charter, which outlines the rights and responsibilities of

patients when they enter the hospital. To its credit, MCMH has posted a patient charter on its website. This charter has been adapted from the American Hospital Association's Bill of Rights and includes provisions for sharing information, processing complaints, and accounting for clients without the ability to pay. However, interviewees at the hospital were not aware of the patient charter, and the charter was not posted in the hospital waiting room or other conspicuous locations. As a result, the impact of the patient charter on the operations of the hospital is not readily apparent. Another aspect of hospital responsiveness is the ability to respond to criticism and resolve disputes. Interviews with staff indicate that MCMH once had a suggestion box, but it had been removed as of the time of this assessment. Additionally, a social worker is in charge of listening to patient concerns and responding to them. Infrequently, disputes are taken to the courts, where they are adjudicated. Finally, user fee transparency is an issue at MCMH. While the user fees have not been changed in 16 years and they are bound in legislation, common user fees are not posted in a conspicuous place in the hospital. Regardless, people can obtain the user fees schedule from the billing department if they have concerns.

3.5 RECOMMENDATIONS

3.5.1 SHORT-TERM RECOMMENDATIONS

Develop a dissemination strategy for the Ministry of Health, Wellness and the Environment Annual Report

The MOHE has an opportunity to garner goodwill from civil society and provider organizations through the annual report. Developing a dissemination strategy that includes town halls, radio interviews, and a high-level forum to discuss the statistics and findings in the annual report would allow citizens to have more information on their health system and give civil society the opportunity to develop independent analysis of health statistics. This type of information sharing is crucial to getting civil society feedback and collaboration on health system challenges.

Implement new legislation and legislative updates to strengthen governance structures

There are several pieces of new and updated legislation that have been recognized as a need but remain lacking or pending for years. The delay in their passage and implementation significantly weakens health governance structures in Saint Vincent. Passage and implementation of the FOIA, for example, would improve citizen access to routine information and strengthen the fight against corruption. Legislation protecting PLHIV is another example; while the MOHE has recognized a need for this legislation in the Strategic Plan for Health, no draft has yet been proposed. Similarly, legislation to regulate services at the MCMH and district hospitals and health centers is a critical need. These and other examples of legislative initiatives, if passed and implemented, could become the key ingredients for further improvements in the health sector.

Strengthen ties with the Attorney General's office to prioritize key health legislation

Currently, a number of critical pieces of health legislation are stuck at the Attorney General's office. These pieces of legislation are vital to ensuring that registration and education requirements are in place for health providers, pharmacies are properly regulated, and the MOHE has the authority to promote public health. Without the legal authority to enforce standards, provider councils and the MOHE are unable to perform their stewardship role. In order to break this logjam, prioritization of legislation and regular tracking of health legislation is vital. Additionally, advocating for the necessity of these pieces of legislation at the highest levels, including the Prime Minister if necessary, should be considered.

3.5.2 LONGER-TERM RECOMMENDATIONS

Consider alternative governance models for the Milton Cato Memorial Hospital

Given the political challenges to implementing the Hospital Authority Act, the MOHE should consider governance models that would provide improved management structures, without providing full autonomy. This process should include studying other models that have been used regionally or internationally, understanding the benefits and drawbacks of these models, and choosing a model that incorporates those aspects that best fit the needs of Saint Vincent. Some management improvements could be made without changing the fundamental structure of the hospital. For example, hiring a CEO and/or a human resources manager would improve information flow and decision-making processes. Once all options have been considered, the decision of whether to continue creating an autonomous authority for the hospital will be based on a study of all available information.

Develop stronger mechanisms for engaging Civil Society Organizations and citizens

As the voice of specific constituencies, civil society can be an important technical partner in developing policies and priorities and reaching the most vulnerable populations. Engaging CSOs through ongoing forums and discussion is a critical part of both keeping them informed about and obtaining their opinions on health system goals and objectives. These forums should be part of an ongoing dialogue, rather than occurring only during strategic planning sessions.

In addition to engaging civil society, stronger direct citizen engagement on health system issues would improve citizen voice, accountability, transparency, and government responsiveness. Direct citizen engagement could be accomplished through town hall meetings, client provider committees at the health center level, or specific forums with policymakers. These forums do not necessarily need to be formal. Rather, they should provide the opportunity for the public to voice concerns and receive responses. The development of the 2010 MOHE Annual Report offers an opportunity to engage civil society, media, and citizens on health system statistics, usage, and improvements.

4. HEALTH FINANCING

Key Findings

- Plans exist to design an NHI scheme and incorporate it into the structure of the NIS (Social Security)
- User fees are part of the revenue-generation strategy though they currently do not contribute significantly to government revenue
- Understanding of health financing and financing options is limited; the amount of data available is also limited
- The level of out-of-pocket (OOP) expenditure and the contribution of the private sector is unknown

4.1 OVERVIEW OF HEALTH FINANCING

The WHO defines health financing as the “function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people individually and collectively in the health system” (WHO 2000). The WHO further explains that the purpose of health financing is to make funding available and set the right financial incentives to providers in order to ensure equal and effective access to public health and personal health care. As detailed in the World Health Report 2010 (WHO 2010), health financing has three main functions:

- **Revenue collection: raising sufficient funds for health.** This function relates to sources of revenue, the contributing mechanisms (e.g., user fees, OOP payments, private insurance premiums, NHI contributions, and taxes), and the agents that collect these revenues.
- **Pooling of resources: overcome financial barriers that exclude many poor from accessing health services.** This function concerns the extent to which the accumulation and management of funds ensures that individuals avoid having to pay the full cost of care directly as OOP spending.
- **Purchasing: how to procure an equitable and efficient mix of health services.** This function refers to the process by which those who hold financial resources allocate them to those who provide health services (both public and private agencies). The purchasing of health services is either passive (bills are paid upon presentation based on predetermined budgets) or strategic (utilization of a deliberate approach to seeking better quality services at lower prices).

Effective health financing allows the health system to generate and allocate sufficient resources in such a way that it offers efficient and equitable interventions and services.

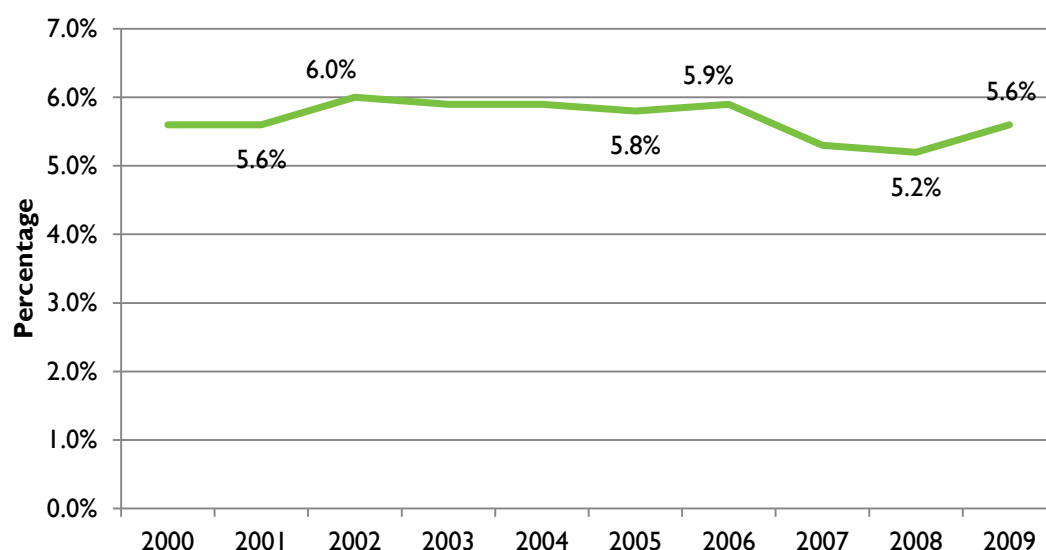
4.2 HEALTH FINANCING INDICATORS AND TRENDS IN SAINT VINCENT

While Saint Vincent conducted a National Health Accounts (NHA) HIV/AIDS subaccount covering HIV spending in 2004, Saint Vincent has never conducted a *general* NHA analysis to create a comprehensive picture of spending flows within the country's health sector as a whole. NHA expenditure data can be used to estimate several important health financing indicators and, when conducted for multiple years, can illuminate trends in spending over time. Due to the lack of general NHA data, the financing indicators for Saint Vincent discussed below are based on imputed calculations by the WHO (WHO 2011a). Annex C presents a table with these and other relevant indicators.

4.2.1 TOTAL HEALTH EXPENDITURE IN SAINT VINCENT

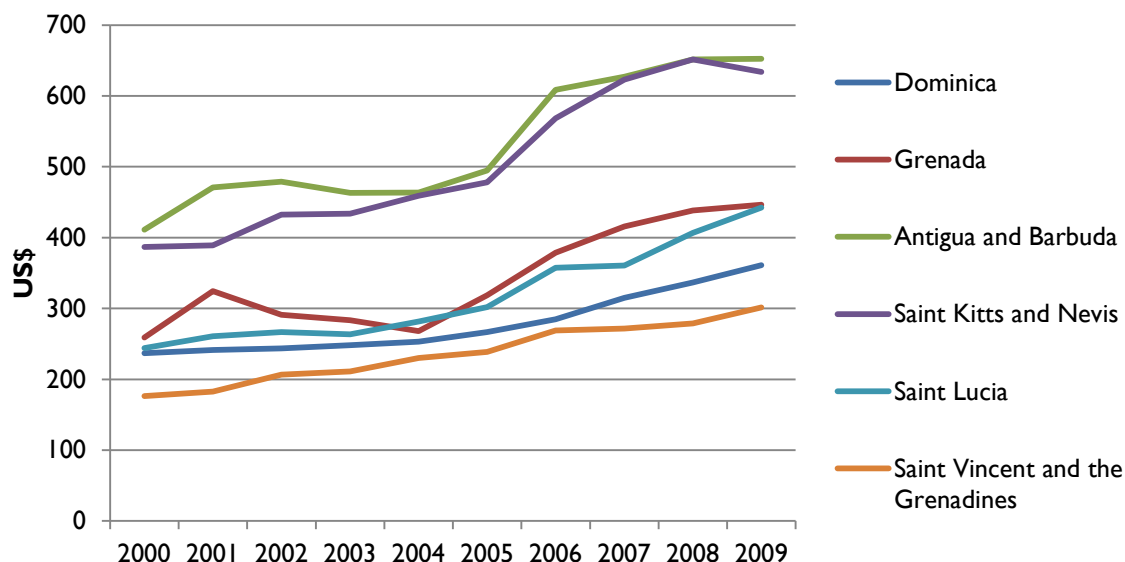
Per capita health spending is rising in Saint Vincent but remains low by regional standards. Saint Vincent's total health expenditure as a percentage of GDP has fluctuated around 5.6 percent over the past decade, as Figure 4.1 shows. Among the OECS countries, this proportion is the second lowest, higher only than the 5.1 percent spent on health in Antigua and Barbuda. In absolute terms, Figure 4.2 shows that Saint Vincent spent less on health per capita than all other OECS countries did. Health expenditure per capita in Saint Vincent increased steadily between 2000 and 2009, reaching US\$301 in 2009. Because Saint Vincent uses the Eastern Caribbean Dollar, which is pegged to the U.S. Dollar and thus has shown low levels of inflation during this period, the upward trend in this data reflects a real increase in health expenditure per capita.

FIGURE 4.1: TOTAL HEALTH EXPENDITURE AS PERCENTAGE OF GROSS DOMESTIC PRODUCT



Source: WHO (2011a).

**FIGURE 4.2: HEALTH EXPENDITURE PER CAPITA
IN THE ORGANIZATION OF EASTERN CARIBBEAN STATES COUNTRIES (US\$)**

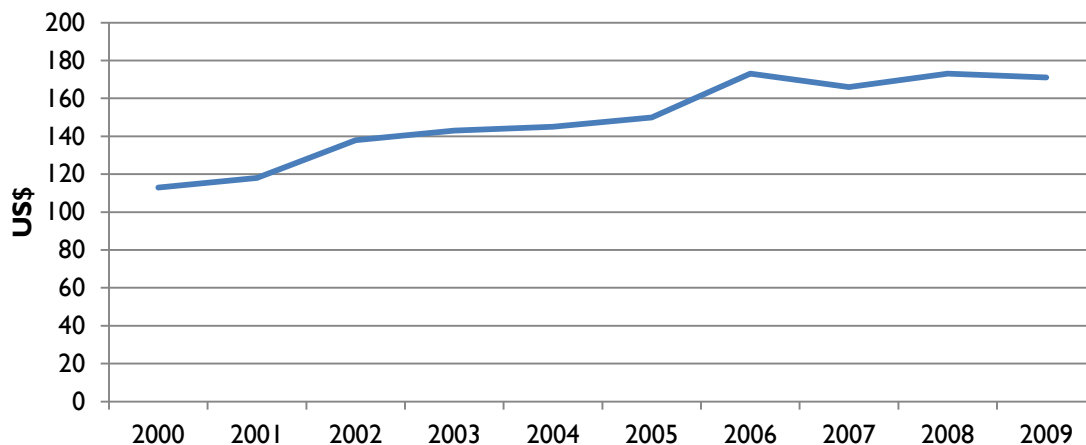


Source: WHO (2011a).

4.2.2 GOVERNMENT CONTRIBUTION TO HEALTH FINANCING

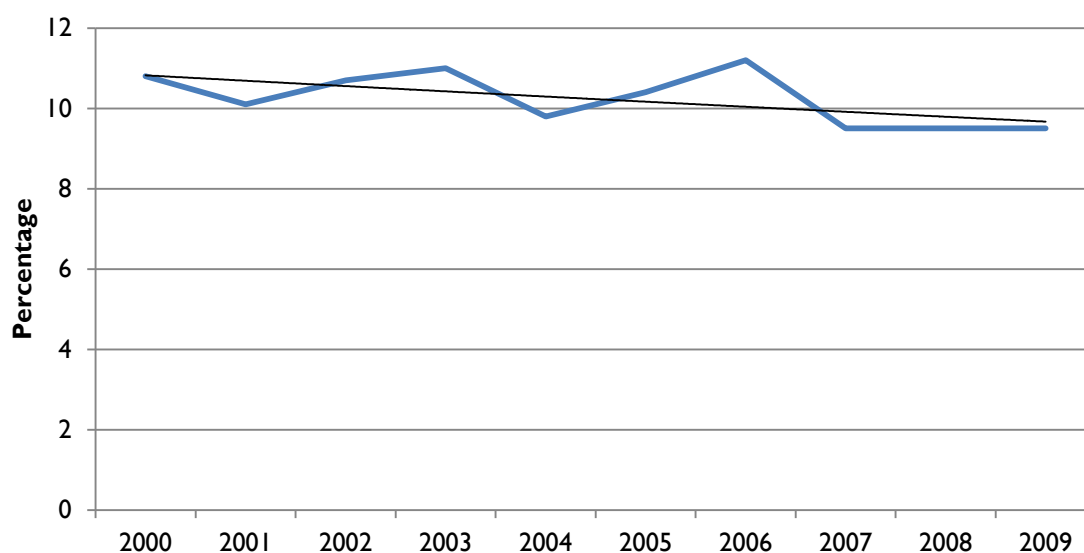
Government health expenditure per capita reached US\$171 in 2009 (at average exchange rate), after increasingly steadily over the last decade. However, government expenditure on health as a percentage of total government expenditure decreased slightly over the same period, falling to 9.5 percent for the years 2007 to 2009. More recent data indicate that these trends are likely to continue into the future, with government recurrent health expenditure in Saint Vincent in 2011 accounting for 9.3 percent of the overall government budget (GOSVG 2011a). Figures 4.3 and 4.4 show these trends.

**FIGURE 4.3: GOVERNMENT HEALTH EXPENDITURE PER CAPITA
(AVERAGE EXCHANGE RATE US\$)**



Source: WHO (2011a).

FIGURE 4.4: GOVERNMENT HEALTH EXPENDITURE AS PERCENTAGE OF TOTAL GOVERNMENT EXPENDITURE

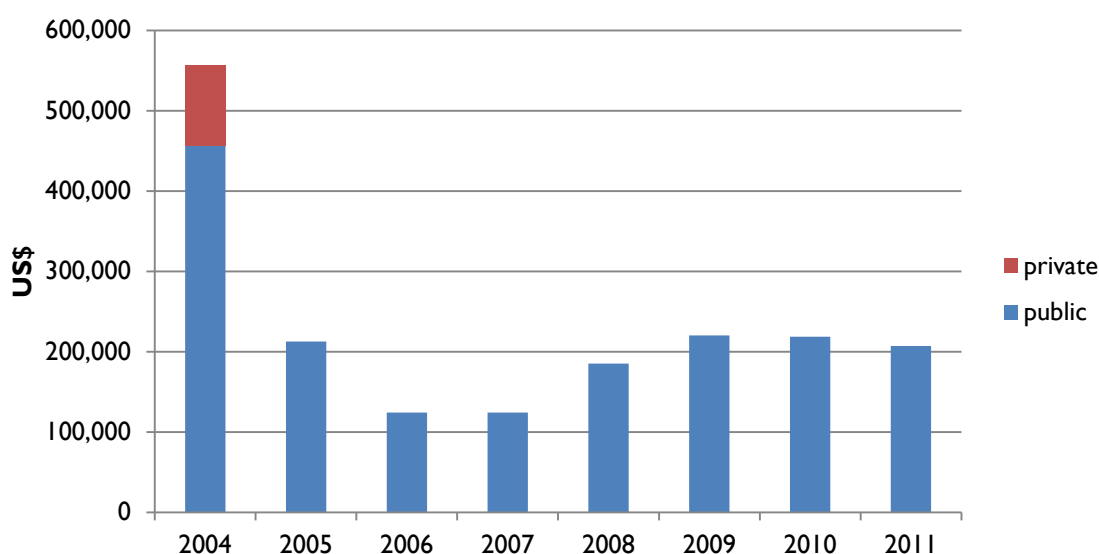


Source: WHO (2011a).

4.2.3 GOVERNMENT SPENDING ON HIV/AIDS

Figure 4.5 shows domestic spending on HIV/AIDS in Saint Vincent (all figures in nominal US\$) between 2004 and 2011. Estimates for the 2004 fiscal year come from an NHA HIV/AIDS subaccount conducted in 2006 and include both public and private domestic spending on HIV. Estimates from 2005 through 2009 come from UN General Assembly Special Session on HIV/AIDS (UNGASS) reports. While 2004 estimates from the NHA subaccount show higher domestic spending in 2004 than in the following years, this increase is most likely largely due to differences in data collection and analysis. According to UNGASS reports, annual public sector domestic spending on HIV/AIDS in Saint Vincent varied from approximately US\$120,000 to US\$210,000 per annum between 2005 and 2009. These estimates refer to public spending alone. Estimates from the Saint Vincent Revenues and Expenditures 2011 (GOSVG 2011a) indicate that public spending is leveling off at around US\$200,000 per annum. These estimates come from the line item covering the program on HIV/AIDS and STI Prevention and Control.

FIGURE 4.5: DOMESTIC SPENDING ON HIV/AIDS IN SAINT VINCENT



Source: Joint United Nations Program on HIV/AIDS (UNAIDS) and Abt Associates (2006), GOSVG (2006), GOSVG (2008), GOSVG (2010a), GOSVG (2011a)

4.2.4 DONOR CONTRIBUTIONS TO HEALTH

External resources for health make up only a small part of Saint Vincent's total health expenditure. WHO estimates show that external resources were negligible between 2000 and 2005 and averaged only 2.1 percent of total health expenditure between 2006 and 2009 (WHO 2011a).

Currently, the EU, through the 10th European Development Fund (EDF) agreement signed in July 2011, is supporting major investments in health systems strengthening. These funds are intended to upgrade MCMH, establish polyclinics, improve mental health services, and support NHA and other agreed-upon reforms. The Caribbean Development Bank (CDB) is also active in Saint Vincent; in 2010 the CDB approved loans for US\$380,000 for renovations to Bequia Hospital and US\$250,000 for construction at the Port Elizabeth Clinic.

Other major multilateral contributors to health support Saint Vincent's HIV response. Loans from the World Bank have supported the HIV/AIDS Prevention and Control Project from 2005–2011. The total value of the World Bank funds for this project came to US\$7 million: 50 percent loan, 25 percent credit, and 25 percent grant from the International Bank for Reconstruction and Development and the International Development Agency (World Bank 2011c). (For more information on this project, please see Section 5.3.2, Vertical Programs in Chapter 5, Service Delivery.) The Global Fund has supported the HIV response at a regional level. Through a Round 3 grant to the OECS, Saint Vincent has been able to provide ARVs, and a Round 9 grant to Pan Caribbean Partnership Against HIV and AIDS (PANCAP) will continue to support treatment. A previous PANCAP grant has also funded a National Law, Ethics and Human Rights Assessment. Finally, U.S. government agencies have supported HIV-related activities through the President's Emergency Plan for AIDS Relief (PEPFAR), providing a total of US\$2 million in grants during the two year period 2010–2011. The U.S. Centers for Disease Control and Prevention has focused on laboratory strengthening while other U.S. agencies such as the Health Resources and Services Administration, Peace Corps, and the State Department have focused on prevention and health systems strengthening.

Additionally, Saint Vincent has received external funding for health from several bilateral partners. The Republic of China/Taiwan and Venezuela have supported the Oxygen Production Plant on the island. Cuba has provided technical assistance to allow Vincentians to receive ophthalmology services in Cuba

or to get care from visiting specialists. Cuba has also provided financial assistance in constructing the Modern Medical Complex in Georgetown and, according to interviewees, has agreed to staff it for the first two years after its opening. Table 4.1 shows the 2011 estimated donor contributions.

TABLE 4.1: MINISTRY OF HEALTH, WELLNESS AND THE ENVIRONMENT DONOR CONTRIBUTION ESTIMATES 2010–2013

Source	Project	Approved Expenditures 2010 (EC\$)	Estimated Expenditures 2011 (EC\$)	Projected Expenditures 2012 (EC\$)	Projected Expenditures 2013 (EC\$)
Grants					
EU	Equipment for MCMH	0	750,000	0	0
EU	Modernization of health sector	0	500,000	5,000,000	10,000,000
UNICEF	Early Childhood Health Outreach Program	0	440,000	0	0
GEF	Adaptation to climate change in Bequia	1,413,000	1,000,000	0	0
GEF	Mainstreaming of land management	900,000	500,000	800,000	0
ROC	Oxygen plant and bulk storage	2,113,825	0	0	0
GEF	Resource Management	100,000	0	0	0
PAHO	PAHO/WHO Project II	100,000	100,000	0	0
	Total Grants	4,626,825	2,540,000	5,800,000	10,000,000
Loans					
GoVEN	Oxygen plant and bulk storage	0	2,000,000	0	0
World Bank*	HIV/AIDS Prevention and Control Program	3,300,000	1,000,000	0	0
Cuba**	Modern Medical Complex	9,300,000	0	0	0
	Total Loans	12,600,000	3,000,000	0	0

Source: GOSVG (2011).

Note: UNICEF – United Nations Fund for Children, GEF – Global Environment Facility, ROC – Republic of China/Taiwan, GoVEN – Government of Venezuela.

* Specifically, the source of these funds is the International Bank for Reconstruction and Development and the International Development Agency

** Source of funding for the Modern Medical Complex listed as “other” in the expenditures; based on key informant interviews, this source is believed to be Cuba.

Most donor coordination is based within the Ministry of Finance (MOF). Donor funds are negotiated by and channeled through the MOF which then allocates resources to line ministries in the annual budget. Within the MOHE, focal points deal directly with assigned donors. The Health Planning and Information Unit (HPIU) becomes involved only when the MOHE is included within the discussions with donors. During the assessment, interviewees noted that donors lead the process of negotiating assistance much more so than the country.

With the completion of the World Bank-funded program in 2011 and with remaining resources from both the Global Fund and Brazil to end in 2013, questions remain about the sustainability of Saint Vincent’s HIV/AIDS programs. As shown in Figure 4.5 and Table 4.1, current domestic resources for HIV, projected to remain around US\$200,000 per annum, will not make up for the drop in donor funding and in-kind contributions, nor has Saint Vincent formulated a plan for providing the current

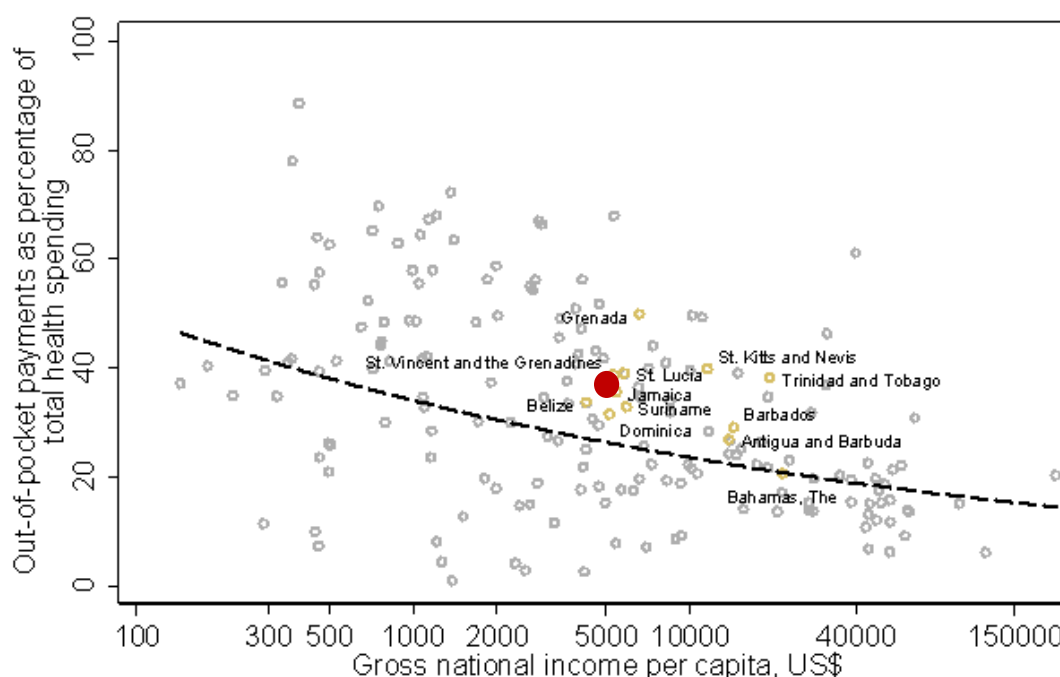
costs of these programs. In contrast, while the sustainability of health care financing is also concerning, as discussed in section 4.3, Health Financing and Management Capacity, the low donor dependence in the health sector overall indicates that the consequences of the challenges to sustainability are not immediate. Nevertheless, with total public debt estimated at 66.8 percent in 2008 (IMF 2009), the government of Saint Vincent faces pressure to fulfill its commitments to creditors and secure a stable macroeconomic environment; in this context, the discussion of sustainable financing for health is critical.

4.2.5 OUT-OF-POCKET SPENDING

Estimates of OOP spending seek to measure the payments that households make directly to providers at the time of using health care services and purchasing medicines. These estimates are used to calculate the ratio of OOP expenditures to total health expenditures as a way to measure the level of financial risk protection currently available to citizens.

In Saint Vincent, OOP spending data are limited due to the fact that no population-wide household health expenditure survey has been conducted independently or as part of a general NHA. Estimates are also hard to infer because the contribution of the private sector to health is unknown. The WHO estimates that all private health expenditures in Saint Vincent are OOP (i.e., little to no private expenditure is pooled through insurance premiums), and that as a percentage of total spending, OOP spending has risen from 36 percent in 2000 to 38 percent in 2008 and 43 percent in 2009. Moreover, the level of OOP spending in Saint Vincent is higher than in other Caribbean countries, as reflected in Figure 4.6. However, it should be noted that these data are not consistent with the Country Poverty Assessment finding that 9.4 percent of the population is covered by insurance, as a nonzero insurance coverage implies that at least some private health spending is not paid directly to providers by households but rather is pooled by insurance.

FIGURE 4.6: OUT-OF-POCKET PAYMENTS VS. GROSS NATIONAL INCOME PER CAPITA, 2008



Note: GDP per capita for Bahamas is from 2007 Source: WHO (2011a), World Bank (2011a)

Though Saint Vincent has not completed a general NHA covering expenditure flows in the entire health sector, there was an NHA HIV/AIDS subaccount analysis conducted for the 2004 fiscal year that used surveys of providers to estimate OOP spending on HIV/AIDS services. Results showed that 18 percent of all expenditure on HIV came from OOP expenditures in 2004; of this amount, an estimated 3 percent came from private insurers and 15 percent from individuals (UNAIDS and Abt Associates 2006).

Another unknown variable in the estimation of OOP and private expenditure on health more broadly is spending on health care outside of Saint Vincent. Some individuals may seek health services outside of Saint Vincent for privacy reasons, or to access more advanced or better care. Current data tracking the number of Saint Vincentian citizens traveling abroad to seek care are limited, but according to the 2007/08 Country Poverty Assessment, 9 percent of survey respondents reported that they traveled to a private doctor or dentist abroad as the first place visited for medical attention (Kairi Consultants Limited 2009). This finding indicates that WHO's estimates for domestic OOP expenditure in Saint Vincent is probably understated. For more information, please see Chapter 5, Service Delivery.

4.3 HEALTH FINANCING AND MANAGEMENT CAPACITY

Health financing and management capacity at the MOHE has strengths and weaknesses. Among its strengths are the strong working relationships with other ministries within the government of Saint Vincent as well as with donor agencies. The EU Feasibility Study noted that there is good internal and external coordination of World Bank and EU programs and resources. It also reported close coordination between the MOHE Health Planner and the MOF. These relationships are critical to, but insufficient to ensure, the proper implementation of health programs (Gillespie and Nielsen 2010).

However, the MOHE has limited human and technical capacity for data analysis and application of data in policy planning. This limits the MOHE's ability to incorporate financing data into the planning process, which has implications for the efficiency and sustainability of Saint Vincent's health programs. Although senior staff have advanced training and skills in health financing, the MOHE does not have enough supporting staff with technical knowledge or awareness of health financing options to implement the work for which the ministry is responsible in an informed way. Interviewees were interested in learning about possible innovative financing options, such as how partnerships with the private sector could play a role in financing and service delivery. One option that seemed unfamiliar but might merit further discussion is how outsourcing of health services from the public to the private sector might improve access and enhance public health care.

These findings, based on interviews conducted for this assessment, mirror findings in the EU Feasibility Study and Financing Proposal (Gillespie and Nielsen 2010). The EU Feasibility Study recognized the high level of expertise among senior staff at the MOHE, but also found the MOHE's capabilities to be constrained by limited capacity overall. The EU Feasibility Study observed that the organizational chart of the MOHE had not been updated for a decade, and that several offices within the MOHE seemed understaffed.

Insufficient capacity at the MOHE might have implications for data processing and project planning and implementation. Available data are limited, as there are too few people in the HPIU within the MOHE to analyze the routine data coming in from facilities; when outbreaks occur, analysis of routine data gets pushed aside so that available staff can respond to more pressing needs. As a result, the MOHE might not be able to provide, if asked, information important to planning and implementation of the NIS (Saint Vincent's Social Security program), which would be responsible for establishing and running the NHI, currently under discussion. The details and status of the NHI project is discussed in Section 4.4.2, Risk Pooling.

Another implication of the insufficient capacity at the MOHE concerns the ability of the MOHE to effectively coordinate and manage implementation of its partnerships with the World Pediatrics

Partnership (WPP), an international NGO active in Saint Vincent. The WPP has established a public-private partnership with the government of Saint Vincent and the Mustique Charitable Trust and, with its partners, plans to build a wing attached to MCMH to serve as a center for pediatric surgery for the region. This partnership has the potential to advance public health in Saint Vincent; however, taking advantage of these opportunities and ensuring that the project is sustainable in the long run will require initiative from the MOHE partners. In particular, it seems urgent that the MOHE identify the full costs of the project and the government's financial commitment to it. This information could then be used to ensure that the wing, when operational, provides additional resources for the MCMH and does not drain public health resources. Currently, it is not clear that the MOHE has analyzed the financial consequences of the new hospital wing, though WPP counterparts reported during interviews for this assessment that they would expect and were willing to participate in further negotiations about planning for recurring expenditures. WPP counterparts are concerned that the failure of the MOHE to define costs and commitments in the development phase will threaten the sustainability of the project in the long run.

4.4 HEALTH FINANCING FUNCTIONS IN SAINT VINCENT

The following section outlines the MOHE's response across the three main functions of health financing (resource mobilization, risk pooling, and resource allocation/purchasing) in Saint Vincent.

4.4.1 RESOURCE MOBILIZATION

TAXATION

The MOHE is funded primarily through general tax revenue, including from income, customs levies, and other sources. According to a study in 2006, taxes on income and profit make up approximately 30 percent of total government revenue (Comision Economica para America Latina y el Caribe [CEPAL] 2006). The income tax is levied on all personal incomes over EC\$18,000 per year and is managed by the MOF. The personal income tax rate ranges from 10.0 percent to 32.5 percent. Foreign nationals working in Saint Vincent are subject to the same tax rate as nationals.

USER FEES

Resources for health are also mobilized through a user fee system. The user fee system was introduced in 1995 as part of the Health Sector Reform Process that began in the 1980s. User fees were introduced for public sector hospital and diagnostic services and pharmaceuticals. The intention behind the user fee system was to improve cost recovery schemes at the MCMH by increasing user fees to generate more revenue and better support the government tax-based contribution, bringing public and private fees into closer alignment, and requiring higher user fees from private patients using public facilities (La Foucade et al. 2005). However, user fees have not resulted in significant revenue generation in Saint Vincent, and arguably should not be used strategically to raise revenue as they have limited potential in this capacity and create regressive structures in health financing.

Despite the initial objectives of generating the user fee system, the 1995 fees were set at low levels that did not correspond to unit costs, as little costing data was available at the time. Rather than have revenue from user fees provide a mechanism for cost recovery, public subsidization at MCMH has remained substantial, particularly for inpatient services where subsidies accounted for 78 to 96 percent of the cost for public patients, and 43 to 72 percent for private patients using the public facility (La Foucade et al. 2005). Private patients of dual practice physicians also pay slightly higher fees to use the MCMH facilities, and subsidies for them account for 43 to 72 of the cost (La Foucade et al. 2005). Interviewees for this assessment stated that, though the private user fees and overall expense are higher, some patients choose to use dual practice physicians through this "private route" in order to increase control over choice of physician, particularly for OB/GYN.

Inflation, while not remarkably high through this period, has nevertheless impeded the ability of the user fee reforms to reach stated goals. The reason is that the 1995 legislation, Milton Cato Schedule of Fees, makes user fees not subject to inflation. Thus, for example, the user fee for pharmaceuticals was set and remains at EC\$5 per prescription despite the escalating cost of pharmaceuticals in Saint Vincent. (For a discussion of pharmaceutical costs, please see Chapter 7, Management of Pharmaceuticals and Medical Supplies.) Because the 1995 legislation is statutory, the user fee system is difficult, and politically sensitive, to amend.

Another factor limiting the ability of the user fee reforms to reach their stated goals of improving cost recovery to generate more revenue concerns problems with implementation. Because user fee revenue does not stay in the hospital but instead is collected by the MOF, there is little incentive among hospital staff to enforce user fee collection. Also, as discussed in Section 3.3, Government Structures in Chapter 3, while the exemption policy does clearly specify who is eligible, its interpretation and implementation varies by site. Overall, interviewees estimated that, due to exemptions and nonpayment by clients billed by mail, only about 20 percent of all user fees are actually paid.

These factors seem to have limited the ability of the 1995 user fee system to achieve stated goals as shown by the perpetually small contribution of revenue from user fees to financing MCMH (La Foucade et al. 2005). This can be seen in the fact that revenue generated from user fees, after an initial rise, actually fell from 7.4 percent in 1997 to roughly 5 percent in 2000 (La Foucade et al. 2005). More recently, the 2011 Estimates of Revenue and Expenditure show that revenues from fees, fines, and permits accounted for only 5–6 percent of the total amount budgeted for MCMH operations and 2–3 percent of the overall health budget between 2009 and 2011 (GOSVG 2011a).

In fact, user fees are not considered to be a tool ideal for raising revenue. First, the potential for raising revenue by setting user fees in line with the cost of service delivery will not necessarily raise funds for the public sector, as these costs might exceed comparable costs in the competitive private sector. In this scenario, consumers will not pay user fees at public facilities but pay lower prices in the private sector, thereby lowering the total value of revenue raised. A second important reason why user fees are problematic as mechanisms for revenue-raising is that high user fees will make it hard for most-at-risk groups to access needed care, making the country's health financing structures less progressive.

User fees can, however, play an important role in influencing consumer behavior. For example, the MCMH is currently experiencing a low bed-occupancy rate but high primary care outpatient visitation. (For more information, please see Chapter 5, Service Delivery.) User fees could be used to reorient the ways citizens of Saint Vincent seek out care in the public sector. It is worth noting that, for user fees to play this role in shaping consumer preferences, it is essential that existing policies are consistently implemented across the country.

4.4.2 RISK POOLING

Risk pooling is an important component in developing appropriate financial risk protection systems, which are crucial to increasing access to health care by the poor and working towards the WHO's goal of universal coverage. Financial risk protection is especially important in a country with a large population of vulnerable households at risk of catastrophic health expenditure. According to the 2007/08 Country Poverty Assessment, 30.2 percent of the population in Saint Vincent falls below the poverty line, estimated at EC\$5,523 annually for 2007/08 (Kairi Consultants Limited 2009). Also, an estimated 16,000 people, or 15 percent of the population, are squatters, and thus particularly at risk from communicable diseases and vermin/rodents in slums (PAHO 2007). Natural disasters such as hurricanes, growing in frequency due to climate change, further exacerbate the vulnerability of poor populations (Kairi Consultants Limited 2009).

PRIVATE INSURANCE

Private health insurance in Saint Vincent is offered by four companies. The Insurance Association of Saint Vincent notes that 18 companies in Saint Vincent provide general insurance, but health insurance is provided by only four: Sagicor, Coreas, Colonial Life Insurance Company (CLICO), and British American Insurance Company (BAICO). These companies cover the estimated 9.4 percent of the population in Saint Vincent that reported holding health insurance (Kairi Consultants Limited 2009). Of those covered, the majority are those who have formal employment-sponsored insurance. The Country Poverty Assessment documents that coverage rates increase with income, with coverage at 3.5 percent in the lowest income quintile and 23.1 percent in the highest. Table 4.2 shows a breakdown of these coverage data.

TABLE 4.2: CURRENT HEALTH INSURANCE COVERAGE (PRIVATE)

Sex	Covered by Health Insurance	Poorest	II Quintile	III Quintile	IV Quintile	V Quintile	Total
Male	Yes	4.3	6.2	6.5	10.3	24.3	10.4
Male	No	94.2	92.6	92.4	87.7	73.5	88.1
Male	Not stated	1.5	1.0	1.1	2.0	2.2	1.6
Male	Total	100.00	100.00	100.00	100.00	100.00	100.00
Female	Yes	2.6	4.0	4.0	10.1	22.0	8.5
Female	No	96.5	95.1	95.2	87.5	76.4	90.2
Female	Not stated	1.0	0.8	0.8	2.4	1.6	1.3
Female	Total	100.00	100.00	100.00	100.00	100.00	100.00
Total	Yes	3.5	5.0	5.2	10.2	23.1	9.4
Total	No	95.3	94.1	93.9	87.6	75.0	89.2
Total	Not stated	1.2	0.9	0.9	2.2	1.9	1.4
Total	Total	100.00	100.00	100.00	100.00	100.00	100.00

Source: Kairi Consultants Limited (2009).

The four insurance companies that provide health coverage have introduced a lifetime maximum coverage for PLHIV. There is however a wide disparity between companies. One company's lifetime maximum was set at EC\$50,000 while another was set at EC\$10,000. Both of these maximums are significantly lower than the major medical lifetime maximum of EC\$1 million offered at Sagicor. It is unlikely that the lifetime maximums for PLHIV are sufficient to support a person living with HIV over the long term.

Recent financial failures in two of the four companies have required regional and national responses and carry implications for insurance holders in Saint Vincent. BAICO and CLICO, operated by separate regional conglomerates based in Trinidad and Tobago, were declared insolvent and are currently under judicial management at the regional level. The collapse of these companies has affected multiple Caribbean countries, creating confusion and concern about how to reimburse policyholders and pay outstanding claims. In mid-2011, eastern Caribbean governments launched the much-anticipated BAICO Health Insurance Support Fund that will provide some relief for policyholders. Additionally, the government of Saint Vincent recently established an EC\$5 million medical insurance fund to cover

holders of BAICO medical insurance in the country (Chance 2011b). Trinidad and Tobago's government is paying EC\$33 million to bail out CLICO, and in April 2011 a regional high court appointed a judicial manager to recover some of CLICO policyholders' assets.

Despite these regional and national responses, some interviewees for this assessment reported that these failures have resulted in a lack of confidence in private insurance companies, and several private insurance providers confirmed during interviews that the failures have resulted in significant fallout. However, this opinion was not consistent across all interviews, with some arguing that the failures did not impact the confidence levels of the population significantly.

NATIONAL INSURANCE SERVICES (SOCIAL SECURITY)

The social security scheme in Saint Vincent is managed by the National Insurance Services (NIS, formerly called the National Insurance Scheme). The NIS became operational in 1987 as a statutory corporation. The institution falls under the portfolio of the MOF and is governed by a nine-member Board of Directors. The aim of the NIS is to provide social security protection to all citizens of Saint Vincent including those living in the country and those in the diaspora.

All employers and employees in Saint Vincent pay mandatory social security contributions. On all income falling below the ceiling of EC\$51,996, employers pay 4.5 percent and employees 3.5 percent to the NIS (Global Tax and Business Portal 2011). The social security scheme, which is comparable to those in the region, offers standard income replacement and compensation benefits for sickness, maternity, employment injury, old age pension, disability, and payment to death survivor; currently, it does not provide general health benefits such as preventative health services (NIS 2011). The government of Saint Vincent does not provide health insurance coverage as a benefit of public sector employment.

NATIONAL HEALTH INSURANCE

Saint Vincent is also exploring the establishment of NHI, an undertaking explored several times before. The government of Saint Vincent has determined that the management of the NHI will be incorporated into the structure of the NIS. Action has already been taken to update and rework the legislation governing NIS. The revised legislation is currently with the Office of the Attorney General for finalization.

The NIS is integrally involved in the planning and operationalization of NHI in Saint Vincent. It has held discussions with ministries including MOHE and MOF as well as representatives from the private insurance companies and other health care providers. It was agreed that private insurance providers would discontinue the provision of policies covering basic medical care and move to providing major medical coverage only¹ (covering surgery and advanced care) as the proposed NHI is implemented.

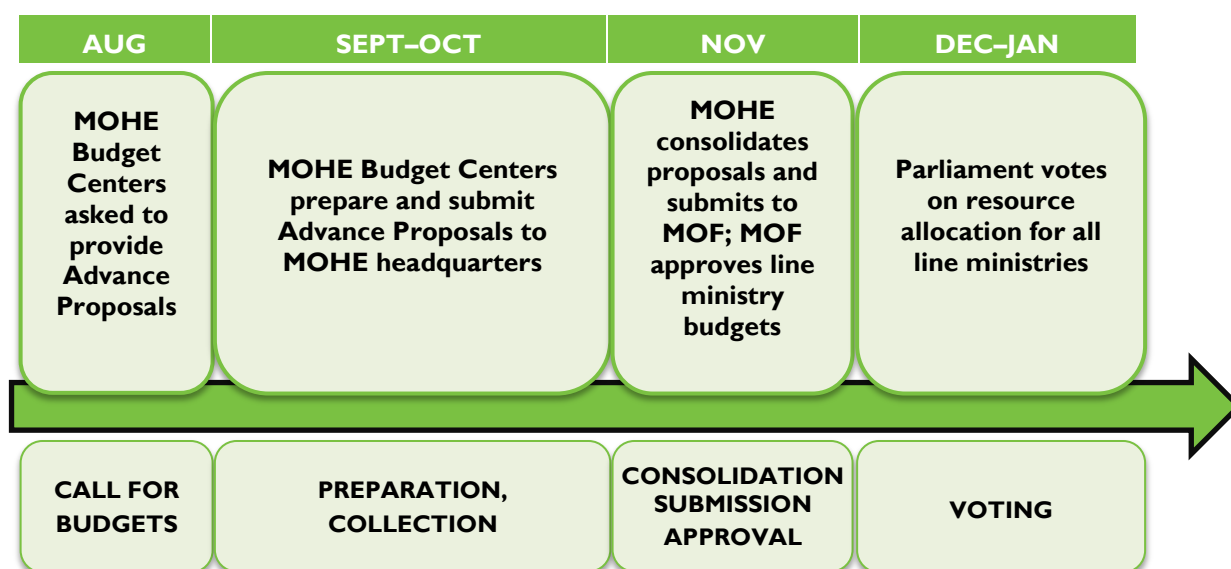
According to interviews conducted for this assessment, the proposed NHI will provide coverage for formally employed workers who contribute to the resource pool, and their dependents. With respect to the indigent population, the government will provide coverage for persons over 60 and the institutionalized. Employed persons between the ages of 16 and 60 will be required to make contributions, based on a 3 percent payroll tax. It has also been proposed that consideration be given to transferring the Employment Injury benefit from the social security component to the NHI component. It is envisioned that the NHI will ultimately provide universal coverage and allow for access to services in the public and private sectors.

¹ As reported in key stakeholder interviews with NIS, the Insurance Association, and Sagicor.

4.4.3 RESOURCE ALLOCATION AND PURCHASING

The budgeting process in Saint Vincent is similar for all line ministries. First, parliament votes on resource allocation for both recurrent and capital budgets. Since 2006, the funds allocated by parliament to the MOHE have increased in three of four budget cycles: by 10 percent in 2007/08, 19 percent in 2008/09, and 16 percent in 2010/11. Only during the global economic recession in 2009/10 did the MOHE budget shrink by 3 percent (Gillespie and Nielsen 2010). MOHE headquarters then works with Advance Proposals (also called Corporate Plans) that are submitted by each of its 50 Budget Centers. These Advance Proposals must be consolidated so that the final budget falls below the MOHE ceiling. Before submission to the MOF, the budget is reviewed by the MOHE Permanent Secretary and Health Planner (Gillespie and Nielsen 2010). Figure 4.7 depicts this process.

FIGURE 4.7: BUDGETING PROCESS FOR THE MOHE IN SAINT VINCENT



Currently, the budgeting process in Saint Vincent and within the MOHE specifically does not operate optimally. Saint Vincent generally relies on a historical budgeting process, meaning that the total amount of funding allocated to various programs is based upon what has been spent in the previous year. This can result in inefficiencies and inappropriate allocations, especially as the country's epidemiological profile and institutional needs change over time. Ideally, budgeting would be linked explicitly to a strategic planning process and information on expected costs of specific programs. High-priority programs would then be given increased allocations over time while funding for lower-priority efforts would be phased out or diminished.

An indication that the budgeting process may need adjustment is the high percentage of MOHE expenditure that is allocated to human resources. In 2011, personal emoluments, allowances, and wages accounted for 89 percent of MOHE recurrent expenditure (GOSVG 2011a). This leaves a very small portion of the total budget to support procurement of supplies and pharmaceuticals, increasing the risk of stock-outs and shortages. Pharmaceutical costs in particular are likely to increase going forward, as the prevalence of chronic NCDs continues to rise. It also leaves very little for such areas as health promotion, which has been deemed a priority in the Strategic Health Plan to address chronic NCDs.

4.5 RECOMMENDATIONS

4.5.1 SHORT-TERM RECOMMENDATIONS

Conduct a broad, systematic review of health financing options and packages

This should include:

- A desk review of health financing options regionally and internationally to identify relevant and feasible health financing solutions for Saint Vincent
- A review of the user fee structure to reconsider the role user fees should play in Saint Vincent's health financing strategy and to standardize the process of exemptions and rules behind exemptions
- A review of plans for the NHI

The review of the NHI will require several steps. First, stakeholders should define how the NHI will function, whether the proposed financing mechanisms will support the operations, and what revisions are needed to existing legislation before the initiative can get approval. Additionally, stakeholders must create a mechanism for monitoring the NHI once it has been operationalized. All of these steps are critical in ensuring that the NHI gets off the ground, is implemented properly, and is financially sustainable.

Conduct a cost-benefit analysis of selected service provision in public and private sectors

Given the rising cost of service delivery in Saint Vincent, coupled with the lack of capacity in the delivery of specialist services, the MOHE should conduct a cost comparison of service delivery in the private versus public sectors for selected high-cost and high-volume services. This analysis will assist in determining whether the MOHE can benefit from outsourcing the delivery of key services to the private sector. The cost comparison should also cover institutions in neighboring territories that the MOHE includes on its referral list. Contracting with the private sector could save the MOHE money in some instances.

Conduct a National Health Accounts analysis

NHA can provide evidence to monitor trends in health spending across all sectors (public and private), health care activities, providers, diseases, and population groups. Furthermore, NHAs can help in developing national strategies for effective health financing and in raising additional funds for health. Data from an NHA can be incorporated into a country's financial projections and could allow policymakers to compare Saint Vincent's health spending profile (for instance) with those of other countries. The EU Feasibility Study also made a strong recommendation to conduct NHA, which, it argues, will offer a mechanism for understanding expenditure flows in health as well as provide key information for policy planning, monitoring, and evaluation.

As part of this work, Saint Vincent should consider advocating for the inclusion of a health expenditure module within the Household Nutrition, Health and Diseases Survey that the EU is planning with the MOHE. According to the EU Feasibility Study, Saint Vincent needs to conduct a food, nutrition, and disease survey in order to better understand the factors driving the rise in prevalence of chronic NCDs, to measure the impact of current prevention programs, and to plan for an effective response moving forward (Gillespie and Nielsen 2010). Because one of the main drivers of cost for conducting NHA is the household expenditure survey, several countries have incorporated an expenditure module into a larger household survey and as a result have realized significant cost savings. By incorporating the household expenditure module into a larger household survey, Saint Vincent could fulfill two goals with greater efficiency and cost savings.

4.5.2 LONGER-TERM RECOMMENDATIONS

Institutionalize National Health Accounts and the tracking of health expenditures

While producing one NHA will help the MOHE in the short run, institutionalizing the process will generate sustained benefits for the country. As part of this process, the MOHE needs to develop routine mechanisms for tracking health expenditures, particularly as they relate to health outcomes. While in recent years there was good compliance with reporting to the international and bilateral partners on resources received, it was not evident that there was ongoing critical analysis of health expenditure to ensure that programs remained within budget. One way to establish this routine tracking is to develop quarterly and annual health expenditure reporting. Tracking health expenditure, developing periodic expenditure reports and finally producing and disseminating NHAs regularly will provide the MOHE with visible products that promote accountability to the populace of Saint Vincent, and allow them to follow health spending trends with benefits for policy planning.

Build the Ministry of Health, Wellness and the Environment's leadership capacity in health financing

A key recommendation is to strengthen the capacity of the MOHE in health financing and health economics. This will include ongoing capacity building in evidence-based planning and program-based budgeting, forecasting, and budget management (including M&E).

Develop a health financing strategy

A health financing strategy should be part of a broader strategy for health. It should include a desk review of the key partners in health and opportunities for financial support (through bilateral partnerships, grants, etc.) in order to identify alternative mechanisms to supplement the financing of health care.

5. SERVICE DELIVERY

Key Findings:

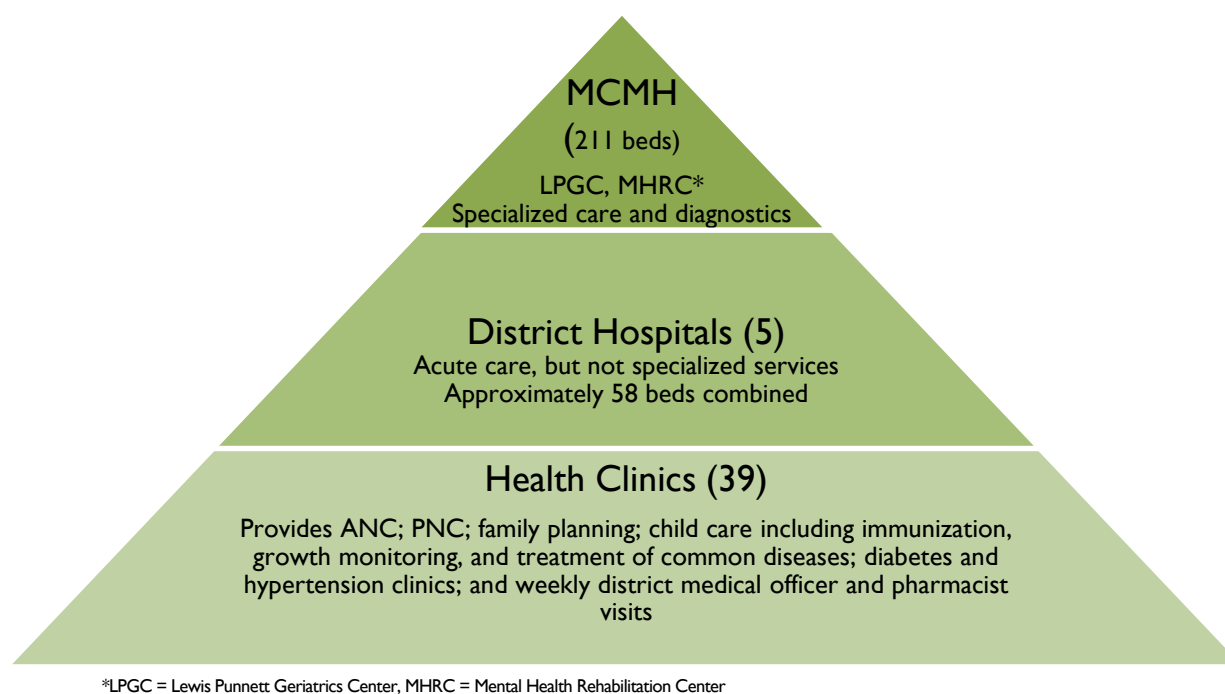
- Primary health care is generally strong and community-based care is ensuring access, though limited diagnostics and hours open create some problems in access
- PLHIV face challenges accessing services due to stigma and discrimination
- The MCMH is overutilized for primary care and rural hospitals are underutilized; this appears to be due to the lack of consistent/daily access to doctors and diagnostics at the primary care level and at rural hospitals
- Inconsistent collection of user fees and lack of clarity on application of exemption rules affect management and performance at public facilities
- Quality improvement mechanisms are weak

This chapter assesses health service delivery in Saint Vincent across the public and private sectors. Health service delivery is the most visible aspect of the health system because it is often where the users interface with the health system. Service delivery is “concerned with how inputs and services are organized and managed, to ensure access, quality, safety and continuity of care across health conditions,” locations, and time (WHO 2007). This chapter presents a brief profile of the performance and process of health services in Saint Vincent.

5.1 STRUCTURE OF THE HEALTH SERVICE DELIVERY

In Saint Vincent, the MOHE provides primary, secondary, and tertiary services through on-island services and off-island care. Tertiary services must be accessed at other regional facilities off-island. As depicted in Figure 5.1, there are 39 public health clinics, five rural district hospitals, and one referral hospital, the MCMH. The health centers are arranged to cover a population of 2,900 within a three-mile radius within each of the nine health districts. In addition, each health center also has a community health team to reach the home-bound populations. Specialized services are provided by the Lewis Punnett Geriatrics Center in the village of Glen and the Mental Health Rehabilitation Center in the village of Villa.

FIGURE 5.1: DIAGRAM OF THE PUBLIC SECTOR HEALTH FACILITIES



Most private sector services are located on the island of Saint Vincent, particularly in Kingstown, although some private providers are available in the Grenadines, including Mustique Island. There are an estimated 25 private physicians in Saint Vincent, most of whom are general practitioners or OB/GYNs. An estimated 42 public sector doctors also practice in the private sector (Yellow Pages 2011; see Section 6.3.3 in Chapter 6, Human Resources for Health for more information). There are three private labs on the island that provide diagnostic services. Maryfield Hospital was a private 12-bed private facility that provided specialty care (particularly OB/GYN); however, at the time of this assessment the facility director indicated that the hospital was no longer operating. Five private nursing homes with a combined bed capacity of 55 offer resident care to the elderly. NGOs also provide some health services in the country. For example, Planned Parenthood provides family planning services, including ANC and postnatal care (PNC) services, three days a week, while organizations such as House of Hope and CHAA provide support services for PLHIV.

Some private businesses, such as the Mustique Company, also offer health services on site. Mustique Island is owned by the Mustique Company, which employs a doctor and nurse to provide clinical care at free and subsidized prices for employees and residents of the island, as well as to tourists. Most Vincentians on the island are Mustique Company employees. The clinic runs special screening days for diabetes and has the ability to do EKGs and x-rays. More complicated cases are referred to the MCMH. Because there are no other health care providers on the island (public or private), doctors at the Mustique Clinic also distribute pharmaceuticals.

While no household survey data on service utilization is available, the survey conducted for the 2007/08 Country Poverty Assessment included questions on the first place visited for medical attention, which sheds some light on population utilization patterns. As table 5.1 shows, the first health care provider visited by most Saint Vincentians (about 50 percent) is a public health center; public hospitals, counted separately, account for 16 percent of first visits. The percentage of first visits for both public hospitals and clinics decreased as wealth increased, with 83 percent in the poorest income quintile, but only 48 percent in the wealthiest quintile, going first to public facilities (Kairi Consultants Limited 2009). In contrast, the poverty assessment survey results show that 21 percent of respondents overall reported

that domestic private providers were the first place visited, and 9 percent first visited foreign private providers; for both categories, percentages increase as income increases: only 6 percent of the lowest quintile and 36 percent of the highest quintile cited domestic private providers, and only 6 percent of the lowest quintile and 13.5 percent of the wealthiest quintile cited foreign private providers. According to interviews with domestic private sector providers, convenience and confidentiality are the most often-cited reasons Saint Vincentians choose private health service providers. Other reasons include shorter waiting times, greater choice, and, to a lesser extent, better quality.

TABLE 5.1: FIRST PLACE VISITED FOR MEDICAL ATTENTION BY QUINTILES (PERCENT)

First Place Visited	Per Capita Consumption Quintile					
	Poorest	II	III	IV	V	Total
Public health center	64.2	57.5	57.3	51.6	32.2	50.4
Private provider domestic	6.1	14.6	21.4	20.2	36.0	21.4
Public hospital	19.1	16.4	11.7	18.3	15.7	16.2
Private provider abroad	6.0	9.4	8.4	5.8	13.5	9.0
Pharmacy	1.4	2.1	1.2	2.2	2.6	2.0
Traditional healer	1.4	0	0	0	0	0.3
Other	1.8	0	0	1.9	0	0.7

Source: Kairi Consultants Limited (2009)

Primary care in the public sector is delivered by the health clinics and district hospitals. The clinics offer limited hours, generally from 8 AM to 4 PM, with a nurse on call while the district hospitals provide 24-hour care with a doctor on call. The District Medical Officer (DMO) and the Pharmacist visit each health clinic in their district one day per week. At the district hospitals, the DMO and Pharmacist generally stop in briefly prior to making daily clinic rounds, time permitting, and then are on duty one day a week at the district hospital. The mental health DMO also runs a weekly clinic at the district hospitals. Diagnostic services are limited at the district facilities; x-ray and labs are not available. EKG machines, which district facilities do have, were not functional at the facilities visited during the assessment.

The MCMH holds a prominent place in public health care provision in Saint Vincent. The MCMH has 211 beds and is the only facility with specialized care in Saint Vincent. Specialized care available at MCMH includes general surgery, internal medicine, pediatrics, gynecology/obstetrics, ears/nose/throat, and ophthalmology. The MCMH delivers over 99 percent of babies born in Saint Vincent (PAHO 2007). While the district hospitals are equipped for deliveries, interviews with the district hospital staff indicate that the standard protocol is that all first deliveries and any higher risk deliveries are referred to the MCMH. Basic diagnostics including laboratory and x-ray services are available at the MCMH. However, the 2010 EU Feasibility Study reported multiple safety issues in the physical structure of MCMH that the MOHE and the Public Works Ministry do not have the resources to address (Gillespie and Neilsen 2010). Also, over the period 2000–2004, the bed-occupancy rate averaged 67 percent, which PAHO has suggested is below the level for optimal efficiency (PAHO 2010a). While this rate indicates that advanced care at MCMH is underutilized, at the same time the Accidents and Emergency (A&E) department of the MCMH is overutilized for primary care needs, according to interviews conducted for this assessment.

Laboratory services are provided by three private labs in Kingstown and the lab located at the MCMH. The lab at MCMH is multidisciplinary and functions both as a clinical lab for the hospital and a public health surveillance lab. The lab's capacity has recently been expanded through funding from the EU. Lab areas include hematology, immunohematology, microbiology, clinical, serology, and histology. Interviews conducted during the assessment indicate that most diagnostics are done at MCMH's lab (no data was made available to the assessment team to confirm this). However, this system is not without problems. In the past, district hospitals collected a limited number of samples that MCMH lab staff would drive out and pick up; however, poor maintenance of the lab's vehicles has prevented this partnership from continuing.

The private labs have sometimes filled needs for the public sector, proving more reliable when testing machinery at the hospital is not operating or when the hospital is out of reagents for testing. One private lab owner who formerly worked at MCMH explained that the hospital may own testing machinery, but it does not always pay the expensive annual maintenance fees. When equipment breaks down, the public sector frequently incurs significant time delays until it is repaired. Private labs cannot afford to rely on this strategy since broken equipment would result in immediate loss of business. One lab owner interviewed reported that 25 percent of his total business was referrals from the public hospital when equipment was out of commission. The lab owner suggested that he would be interested in offering lower fees to the government in exchange for a negotiated contract for services or for concessions on taxes for the importation of certain products. It may be worthwhile for the government to explore the use of private lab services for more complex blood testing, as well as the cost-benefit of subcontracting testing considering the high operational cost of equipment and maintenance contracts.

New facilities in the Saint Vincent public health system are currently in construction and planning phases. The polyclinic in Stubbs is nearing completion, not far from the site where the new international airport is being built. In addition to supplementing the country's capacity for delivering primary care services, the original intention of the Stubbs Polyclinic was to decentralize treatment for AIDS, which currently occurs only at MCMH, and to provide space for visiting specialists in all fields. The Stubbs Polyclinic will provide both HIV counseling and highly active ART (World Bank 2011c). There are plans to upgrade two more health centers in Saint Vincent into polyclinics. A new diagnostic complex is under construction in Georgetown (on the opposite side of Saint Vincent from MCMH) with assistance from the government of Cuba. This facility will mainly provide dialysis but will also have laboratory, x-ray, and ultrasound technology. Additionally, the MOHE, the Mustique Charitable Trust, and the WPP have partnered to manage and oversee the construction and operation of a new pediatric wing at MCMH that will serve medical missions for Vincentians and the citizens of other countries in the region.

5.2 PRIORITY HEALTH AREAS

5.2.1 HIV/AIDS SERVICES

HIV in Saint Vincent has become a priority area in recent years and has received considerable funding from external donors over the last five years. Antenatal testing records indicate that the epidemic has become generalized, but seroprevalence data on vulnerable groups are unavailable. One of the challenges for NAS moving forward, however, will be maintaining the current level of programming aimed at the whole population as donor contributions begin to decline and pressure to allocate more domestic resources to NCDs increases.

Understanding of the HIV epidemic in Saint Vincent is not based on seroprevalence, but available data provide a rough picture of its size. According to the Infectious Disease report compiled by the Senior Nursing Officer at MCMH, there were 63 new HIV cases in 2010 and 28 deaths. In 2010, the total number of HIV cases ever reported reached 1,218 and the total number of deaths ever attributed to AIDS reached 575. These figures imply that there are currently 643 known HIV cases in Saint Vincent

and according to the UNGASS 2010 report, approximately 89 percent of adults and children with advanced HIV were receiving ART in 2009 (GOSVG 2010a).

The HIV/STI clinic at MCMH is the only public facility that provides services beyond VCT for HIV care and treatment. The MCMH HIV/STI clinic operates twice a week, provided that the doctor is in town. When the doctor is out of town, for vacation or for other matters, the clinic does not receive patients. While the HIV clinic operates on the same day and in the same hospital location as a few other clinics to integrate services and increase confidentiality, currently the system does not realize these integration and confidentiality goals. The HIV clinic shares a waiting room with ophthalmology, dentistry, and other specialized outpatient services. Only the HIV/STI clinic's wing of rooms is not labeled, allowing for easy identification of the HIV and STI patients entering the wing. A more integrated setting that could provide more confidentiality to PLHIV might include providing a mix of services throughout the wings of the clinical areas. Confidentiality remains an important issue for PLHIV in Saint Vincent as they face discrimination in most aspects of their lives. A 2005 Health Service Provision Assessment found that only 49 percent of providers surveyed in Saint Vincent had positive attitudes about PLHIV (USAID et al. 2006). During a focus group with PLHIV during this assessment, participants felt that provider attitudes had improved with the MOHE promoting education and awareness of HIV, but that many nurses did not appear to have received training in stigma and discrimination reduction.

In addition to the physical infrastructure at the MCMH failing to promote confidentiality and promoting stigmatization, guarding of a patient's HIV status does not seem to be consistently enforced. In one interview for this assessment, a PLHIV, who had formerly been a prisoner at Her Majesty's Prison in Saint Vincent, noted his experience: a prison official was present during his HIV counseling and testing session. This official breached confidentiality by sharing the interviewee's test results with other guards, with the result that other prisoners found out about the interviewee's HIV status. He experienced discrimination from both other inmates and guards due to this breach of confidentiality.

5.2.2 MENTAL HEALTH

Saint Vincent has been concerned about the increase in admissions and re-admissions to the Mental Health Rehabilitation Center in the last decade. From 2002–2004, the MOHE reported an increase of 10 percent in new admissions (MOHE 2007). Data show that 82 percent of admissions in 2004 were re-admissions (applications for patients needing to return to the facility); in 2005, re-admissions increased to 90 percent of admissions (Gillespie and Nielsen 2010). Currently there is no national mental health policy to address this issue. Staff at the Mental Health Rehabilitation Center estimate that nearly 40 percent of the caseload is for illicit drug-related treatment. At the time of the assessment, there were 198 patients in residence at the Mental Health Rehabilitation Center. Full integration of mental health services into primary care has been challenging because of the limited support staff trained in mental health services available at health clinics. Mental health is an area the EU plans to support in the coming years.

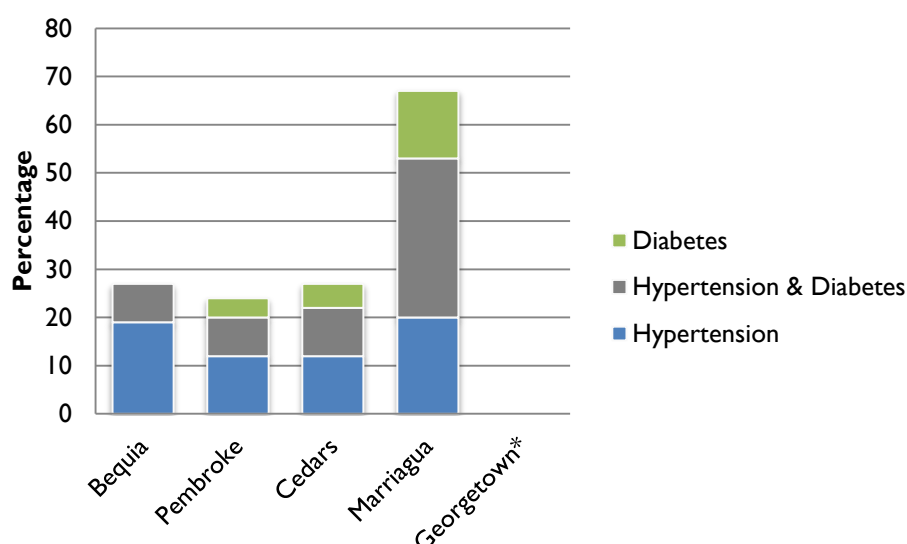
5.2.3 CHRONIC NONCOMMUNICABLE DISEASES

Improved access to services and improvements in treatment for communicable diseases has resulted in longer life expectancy in Saint Vincent (MOHE 2007). As people live longer, chronic NCDs become more prominent, particularly in comparison to infectious diseases, and are creating a serious burden on the health system. Factors that contribute to chronic NCDs include biological factors such as high blood pressure, obesity, high blood sugar, and high blood cholesterol. Other risk factors related to lifestyle include obesity, smoking, unhealthy diet, physical inactivity, and alcohol abuse. Chronic NCDs are considered diseases of lifestyle, a phrase highlighting the fact that the prevention of these diseases at individual and societal levels requires behavioral changes. Chronic NCDs are now among the top causes

of mortality in Saint Vincent. This increasing incidence of chronic NCDs has resulted in rising costs for treatment, creating a growing burden on society.

Hypertension and diabetes account for nearly 70 percent of outpatient visits (Gillespie and Nielsen 2010). Figure 5.2 illustrates the chronic NCD burden at District Medical Clinic sessions. This problem is particularly acute since specialized care, such as dialysis, is currently unavailable on the island, although the new Modern Medical Complex in Georgetown will offer dialysis. According to 2001 census data analyzed in a 2007 report, the four leading health conditions in the country were hypertension, asthma, arthritis, and diabetes (Economic Commission for Latin America and the Caribbean [ECLAC] 2007). These conditions affect men more than women in Saint Vincent. At the same time, women in Saint Vincent have a higher incidence rate for these diseases than women in neighboring islands such as Antigua and Barbuda and Saint Lucia. DMOs have noted in their reports that a particular challenge in combating chronic NCDs is cultural perceptions of body image such that clinically overweight people are not seen as unhealthy and thinness is associated with disease, particularly HIV.

FIGURE 5.2: PERCENTAGE OF ATTENDANCE FOR DIABETES AND HYPERTENSION AT SELECTED DISTRICT MEDICAL CLINICS, 2010



Source: Chateaubelair District Hospital (2010). Georgetown Health District (2010). Marriagua Health District (2010). Pembroke Health District (2010). Bequia Health District (2010)

*The Georgetown Health District report did not contain these data.

5.3 ORGANIZATION OF SERVICE DELIVERY

5.3.1 INTEGRATION OF SERVICES INTO PRIMARY CARE

Health clinics in Saint Vincent offer ANC, PNC, family planning, immunizations, growth monitoring, treatment of common diseases, and diabetes and hypertension treatment. These services are provided on a rotating schedule, with each day dedicated to a particular service. Only VCT is offered on a daily basis at the health clinics across Saint Vincent, though ART treatment for HIV must be referred to MCMH. Integrated services, where a patient can receive care for any issue, are considered ideal (Islam 2007). The inability to access all service in one stop could be contributing to some of the bypassing of care at the health clinic level as patients are looking for more convenient services. MCMH offers integrated care so that a patient may address all of his or her health needs in one day rather than make multiple visits to the district health clinic on separate days. In the EU's 2010 Feasibility Study, a

supermarket shopping approach was recommended so all health services could be accessed at one time (Gillespie and Nielsen 2010). While best practice suggests that integrated care is the most appropriate method of service delivery, this approach may not be feasible given the constrained human resources in Saint Vincent. In this case, service provision should focus on clustering services that will accommodate patients as much as possible. Examples include clustering well-baby check-ups with family planning services and ensuring that services aimed at men do not overlap with sensitive services for women. In the health clinics visited, services were arranged in this clustering fashion to allow for family planning, general gynecology and postnatal care on the same day.

Previous strategic health plans and health profiles have indicated that Saint Vincent hopes to integrate services more, particularly for HIV and mental health. However, during this assessment, none of the clinics visited could actually provide VCT on request due either to stock-outs of rapid testing kits or unavailability of staff to perform the tests when occupied with other health sessions. Mental health is still not integrated into primary care services and is delivered through community-based staff from the Mental Health Rehabilitation Center, who travel out to five locations and sometimes make home visits.

5.3.2 VERTICAL PROGRAMS

Saint Vincent has a number of vertical programs, including those for HIV and STIs, family planning, nutrition, and mental health. This HSA did not find that these programs are well integrated with other programs, with the exception of the nutrition program and the family planning program, which is incorporated into maternal and child health services.

The HIV/AIDS program has been funded primarily by the World Bank, with contributions from the government of Saint Vincent. Future funding for ARVs has been secured through Global Fund grants which will allow them to be distributed to patients for free for at least two more years (through 2013). The goal of the World Bank's program, which ended in 2011, was to scale up preventative programs, particularly for high-risk groups; strengthen treatment for PLHIV through integration with primary care; reduce stigma; and build capacity at MOHE and other institutions involved with HIV prevention and treatment. According to the World Bank's February 2011 evaluation, the MOHE made significant progress on several key outcome and intermediate outcome indicators such as the number of reported new HIV cases, which declined by 41 percent, as well as the number of new AIDS cases, which declined by 56 percent. Other remarkable improvements are the number of individuals tested for HIV, which reached 8,927 for the period January 1, 2010 through September 30, 2010, exceeding the target of 2,000; and the number of public facilities staffed by trained counselors providing specialized HIV counseling and testing, which reached the target value of 39 (18 of these facilities provide rapid testing) (World Bank 2011c).

Although these changes do reflect real improvements in Saint Vincent's service delivery for HIV, several qualifications are important to note. First, achievement of the World Bank's program targets does not necessarily imply that the country's targets were achieved. For example, as stated above, the World Bank's target for number of individuals tested for HIV was exceeded, but the target as stated in the Saint Vincent National Strategic Plan for HIV/AIDS was to test 50 percent of people between the ages 18–59, and the program clearly did not allow for the country to reach this goal. Another qualification is, given the small population in Saint Vincent, small changes in numbers can produce large percentage changes. For example, the percentage of pregnant women who are HIV-positive who are provided with treatment and care actually decreased from 95 percent in 2004 to 82.4 percent in 2010 due to three individual cases (World Bank 2011c). Further, while health facilities were staffed with trained staff for VCT, during this assessment the facilities visited were unable to provide VCT on demand due to lack of tests at the facilities or limited staffing available to conduct the test if someone requested it during busy clinic hours. Also, these indicators do not measure how well HIV prevention and treatment services have been integrated into primary care; nor do they speak to concerns for the sustainability of the gains

made during the project implementation period from 2005–2011. A final qualification concerns treatment. As will be discussed in Chapter 7, Management of Pharmaceuticals and Medical Supplies, limited staff have received training for ARV counseling and stock-outs of ARVs were also reported, both of which affect the quality of care for PLHIV.

5.3.3 REFERRAL SYSTEMS AND THE CARE CONTINUUM

A combination of factors inhibits effective continuity of care for patients receiving services in the public health system in Saint Vincent. To begin with, patient health records have traditionally been kept on paper and stored at the health facility. Saint Vincent utilizes a referral system from primary care to secondary care, but this only works when patients first present at the health clinic or district hospital for care, receive a clinical provider written referral sheet with a description of their most recent episode of care, the reason for their referral to the next level, and whether there are any known issues that could complicate the patient's care. In principal, the referral sheet would then be updated by the provider at the secondary level and returned with the patient to the primary care level for follow-up. The more frequent occurrence in Saint Vincent, based on numerous stakeholder interviews with patients and providers alike, is that patients bypass the health clinic or district hospital and self-refer to MCMH, which leads to a discontinuity of care across the system.

The electronic health management information system (HMIS) currently being rolled out in Saint Vincent is expected to address this issue to a certain extent as patient information will become available electronically at all points of care in the system. However, this electronic information will be only as good as the data entered into the HMIS, which will likely not include the full patient history on all patients who have ever been seen across the health system. Saint Vincent's HPIU does not have the resources (financial or human) to backfill into the HMIS the medical records of all patients seen across the system. This information will only become available as patients are seen for the first time at a health facility after that facility has implemented the HMIS system. For more detailed discussion on this topic, please see Chapter 8, Health Information Systems.

The private sector makes referrals to MCMH as necessary for advanced care and surgery or to a dual practice physician. No formal referral system between the public and private sectors exists. In addition to public sector physicians, only dual practice physicians have access to the facilities and equipment at MCMH. No data on patients is required to be shared between public and private providers. In some cases, the MOHE informally engages with the private sector, often for one-off services in a subcontracting relationship. By more actively and openly discussing these types of relationships, the MOHE could identify alternative solutions and resources for reaching its priority objectives and maximize the resources available on the island; in order to do so, the MOHE needs to clarify its top priorities, because approaching public-private partnerships without linking them strategically to objectives might create a burden of management on the public sector rather than a mechanism for increasing resources for public providers and increasing access for the public.

The district hospitals have ambulances assigned to them. However, site visits showed that the ambulances are often not well maintained and are out of service. Additionally, in some instances, the ambulances are being used not only to transport patients but also to pick up items like groceries for the district hospitals, which keeps the nurses traveling with the patients and the ambulance away from the facility for the majority of the day. Stakeholders interviewed reported transportation from the Grenadines can be problematic when outside of the normal operating hours of ferries or charter planes.

5.3.3 HEALTH OUTCOMES

Health outcomes, as shown by the indicators in Table 5.2, are strong and generally higher than the average in the LAC region for almost all indicators. One exception is contraceptive prevalence, which averages at only 48 percent in Saint Vincent as opposed to 75 percent in the LAC. While use of

contraceptives for women in Saint Vincent has grown in recent years with increased family planning options available through the National Family Planning Program, the lower contraceptive prevalence rate indirectly suggests that family planning is not easily accessible or that there are other social constraints preventing uptake.

TABLE 5.2: SERVICE DELIVERY INDICATORS FOR SAINT VINCENT COMPARED TO LATIN AMERICA AND THE CARIBBEAN REGION

Health System Indicator	Saint Vincent	Year of Data	LAC Average	Year of Data
Number of hospital beds (per 10,000 population)*	30.00	2007	20.08	2007
DTP3 immunization coverage of 1-year-olds*	99.00	2009	88.59	2007
Births attended by skilled health personnel (%)**	99.20	2008	94.42	2007
Contraceptive prevalence (% of women ages 15–49)**	48.00	2006	74.71	2009
Pregnant women who received 1+ antenatal care visits (%)***	99.50	2008	95.01	2009
Mortality rate, infant (per 1,000 live births)**	11.20	2009	18.92	2009
Mortality rate, under-5 (per 1,000 births)**	12.40	2009	22.55	2009
Maternal mortality ratio (per 100,000 live births)**	93.00	2000	103.46	2008

Source: * World Bank (2011a). **World Bank (2011a). *** UNICEF (2010).

Compared to the regional average, Saint Vincent also has a higher number of available hospital beds. Recent reports by the EU (Gillispie and Neilsen 2010) and PAHO (2010a) have suggested that the bed-capacity rate may be higher than needed for Saint Vincent. The bed occupancy rates have been documented at 63.5 percent in 1997, 60.0 percent in 2000, and 70.2 percent in 2004 (La Foucade et al. 2005; MOHE 2007). Several of those interviewed for this assessment did report that patients overutilized MCMH; however, these reports relate to those patients visiting the A&E unit for primary care needs, not the use of hospital beds for more advance care. Only 0.38 percent of patients treated in the A&E unit from 2000–2004 were critical. On the contrary, many patients report to the A&E unit for routine primary care services (MOHE 2007).

5.3.4 AVAILABILITY OF SERVICES

Availability of services examines the degree to which facilities are functional, adequately staffed, equipped, and supplied, and available to the public. In Saint Vincent, geographic access to primary care services through the health clinics is sufficient, as patients generally no more than three miles to reach a facility. There are, however, limitations with the system, such as limited diagnostics or limited hours when facilities are open or when doctors are available, that encourage people to circumvent the primary care level. There is a concentration of specialized and private services in Kingstown, which is to be expected given the small size of the country. Reaching Kingstown from other parts of Saint Vincent is generally possible via public transportation, though people living in the Grenadines must travel by boat or airplane. There is also currently no formal ambulance service (neither air nor ferry) from the Grenadines to Kingstown for patients needing to be transported to MCMH for urgent care.

The private sector also serves an important role in the medical supply chain by providing convenient access to a choice of medical and paramedical products. Price margins on private sector medical products are limited because prices are regulated and private practices compete on price. Overall, this regulation and competition benefits consumers. Some private providers offer advanced treatment not available in the public sector. For example, private sector dentists offer root canals, advanced extractions, crowns, and emergency treatment as well as advanced imaging and orthodontics. When demand is sufficient, private providers often organize to fly specialist doctors such as cardiologists and

neurologists from overseas on a regular basis with benefits for all actors involved: providers in Saint Vincent and the foreign specialists make a profit, consumers save money, as the cost of receiving care in Saint Vincent is lower than the combined cost of transport and services abroad, and the country overall gains as health care availability increases. In other cases, private sector services provide references and help create contacts with off-island specialists.

Private pharmacies and labs are also important in the supply chain in Saint Vincent. Many Vincentians seek help for medical concerns at private pharmacies before going to a clinic or doctor, and some offer a wider variety of branded medication than is available in the public sector. Medical services such as private labs play a role in the health supply chain since they supply services to private providers. Labs feature a variety of blood tests, ranging from the standard to more complex. The labs sign contracts with local providers, guaranteeing them prompt service for a discounted fee. These contracts ensure the volume necessary to run a profitable lab business. Interviews for this assessment also reported that private labs are often able to provide test results to doctors more quickly than public counterparts.

Financial barriers to primary and secondary care in the public sector were generally found to be low based on interviews conducted during the assessment. Primary care at the health clinics is provided free of charge and a small user fee of EC\$5 is needed for filling prescriptions. This user fee for prescriptions, however, is inconsistently applied or often waived at the discretion of the providers. In the district hospitals, an EC\$10 user fee is also commonly waived. User fees are higher at MCMH, but the exemption policy is so broad and unevenly applied that nearly everyone who asks for an exemption is granted one. The exemption policy varies by site, but generally was believed to hold for the poor, those under 16 and older than 65, and for all essential public health and safety workers. Financial need is recorded on the patient's prescription or file by the doctor or nurse based on their personal assessment but not based on formal documentation requirements. For hospital services, a more formal appraisal is done by social workers, although no written guidelines were available for review by the assessment team. Ideally, the rules for granting user fee exemptions would be clearly outlined, allowing nurses and others conducting the appraisal to enforce them systematically and explain them to clients.

While primary and secondary care is affordable in public facilities, financial barriers exist for accessing tertiary care. Tertiary care is only available in the private sector and overseas. The MOHE has some financial assistance available for all citizens; however, these resources are not sufficient to cover the full cost and, as noted in Section 4.4.2, Risk Pooling, only about 9.4 percent of the population has health insurance.

Interviewees reported that district hospitals were inadequately stocked with consumables (such as gloves and in some instances food) and certain pharmaceuticals (including aspirin), and that some pieces of equipment like EKG machines were malfunctioning. A common factor causing stock-outs of consumables, based on interviews conducted, appears to be that district pharmacists do not have the time or training to accurately forecast needs. Issues have also been reported with support staff such as cleaners or drivers not reporting for duty, which disrupts provision of services. District pharmacists are administrative supervisors for district hospitals, but are often attending health clinics throughout the week and are thus not available at district hospitals to deal with human resources issues. As with district hospitals, interviews indicate that clinics also experience stock-outs of pharmaceuticals. Clinics reported issues such as broken air conditioners in the pharmacies, which poses a risk for the medicines stored there. Most of the rural facilities reported lack of adequate staffing due to absenteeism and the lack of replacement staff.

5.4 QUALITY ASSURANCE

To ensure the clinical quality of health services, health systems must define, communicate, and monitor the quality of care. This information is used by policymakers and providers to improve quality. Quality is also impacted by the motivation of providers to implement standards of care. In Saint Vincent, the

MOHE recognizes the need for improved policies and information to ensure the quality of care; however, to date this initiative has not been realized.

There is no overarching National Medicines Policy that guides the development, implementation, and monitoring of standards, protocols, or procedures. Only the Pharmacy Act, regulated by the Pharmacy Council, provides standards for the registration of facilities, but not for their licensing. Draft regulations, not yet passed, for the Pharmacy Act would implement a structure to license the health facilities. There are no accreditation policies on the island, although the framework for the NHI, proposed in 1999, includes provisions for accreditation.

In interviews conducted at the health clinics for this assessment, some nursing staff did not know about the national standard guidelines they were supposed to follow for clinical treatment while others referred to a community nursing manual. The facilities visited did have flow charts for services posted on the wall. The Chief Nursing Officer (CNO) had procedure manuals for community nursing staff and family health which outlined various procedures and reporting mechanisms. The assessment team did not find similar guidelines for doctors; however, pharmacists noted that there are regional treatment guidelines for HIV adopted by Saint Vincent in 2004 and which include discussions of referral and follow-up systems.

The Senior Nursing Officer for Community Health supervises ward sisters at the district hospitals and staff nurses at the health centers while the District Pharmacy Supervisor oversees district pharmacy staff. For the most part, the supervision appears to take place through monthly discussions on service delivery statistics, which are reported back to the MOHE in a standardized format across the districts. Depending on the district, some supervisors reported on quality issues in the regular reports. There were no indications that the visits provided any opportunity to dialogue and provide substantive feedback about the quality of care, key markers of effective “supportive supervision.” Supportive supervision improves quality by “strengthening relationships within the system, focusing on the identification and resolution of problems, and helping to optimize the allocation of resources, promoting high standards, teamwork, and better two-way communication” (PATH Children’s Vaccine Program 2003).

In addition to supervision, quality is also monitored through customer complaints. The revised laws of Saint Vincent² allow for patients of MCMH to seek redress of any complaints from the surgeon or speak with the CMO, who will investigate. This mechanism exists only at MCMH. Interviewees reported that this mechanism is rarely used for quality complaints, but rather for complaints of a more personal nature. In practice, most complaints go through the hospital’s social workers. Although patients used to actively use a Patient Suggestion Box, interviewees said that no one from the MOHE has come to pick up the suggestions in quite some time in order to obtain this feedback.

The EU Feasibility Study found that confidentiality was an issue as access to medical records was uncontrolled and manual entry of data led to the loss of information (Gillespie and Neilsen 2010). In most public clinics, patients filling prescriptions do not have private space away from the waiting area to discuss their medications. Only recently has the MCMH added an enclosed area for prescription counseling. In the private sector, the space for confidential patient counseling is supposed to be regulated but not all facilities have this. A perceived lack of confidentiality in the public sector has prompted many patients to access services in the private sector, particularly for HIV services. Despite free services in the public sector, a number of patients will go to a private physician and pay for ARVs at a price of EC\$300–\$400 for one month.

² Laws of Saint Vincent in force on January 1, 1991 under Title XVII, Health, Education, and Social Services.

5.5 COMMUNITY-LEVEL PARTICIPATION AND CARE

Community-level participation in service delivery is limited in Saint Vincent. Local health committees do not exist. Although there is an active community nursing program that provides home visits and health promotion, no mechanism currently functions to solicit feedback in the community. The Nurses Association and Senior Nursing Officer have conducted patient satisfaction surveys at MCMH, but these surveys are not conducted at the community level. Some districts have diabetes or hypertension groups that have provided some support or services for populations in their community living with these conditions; these groups could play a larger role in health promotion if given appropriate support from the MOHE. Community groups worked with NAS as recipients of small grants; however, with the end of the World Bank funding for the program in 2010, civil society grants have ended and it is unclear what future engagement will be like without this component. NAS, in coordination with civil society groups, has provided peer educators and community animators to promote HIV prevention and care in the community.

5.6 RECOMMENDATIONS

5.6.1 SHORT-TERM RECOMMENDATIONS

Reorganize the Milton Cato Memorial Hospital outpatient specialty clinic in order to reduce stigma

Addressing stigma is more than just training; it requires a commitment to ensure that infrastructure is not stigmatizing as well. In the case of the outpatient clinic, the HIV posters located only in the hallways where these services are provided, while well-meaning, signify to everyone where the HIV services are being provided. In order to remedy this situation, the assessment team suggests that MCMH remove the HIV posters and rotate the exam rooms that the HIV clinic and other outpatient services use in order to improve confidentiality. Conducting an HIV stigma self-assessment, using one of the many available off-the-shelf tools, could help MCMH identify other areas for reducing stigma against PLHIV.

Standardize exemption policies for prescriptions and hospital services

Health system staff currently make subjective decisions about who is eligible for user fee exemptions. The policies are not evenly enforced throughout the districts. Clarifying and creating specific criteria for who is eligible for user fee exemption and distributing written guidelines nationally could ease some of the burden on the staff in making these evaluations.

Create clinical practice guidelines for priority health areas to promote standardized, quality care and more cost-effective treatments

Just as the community nursing program has created a procedure manual for critical health issues, the MOHE should develop clinical practice guidelines for doctors and pharmacists to follow for priority areas such as chronic NCDs (particularly hypertension and diabetes). Having guidelines for these areas will help to ensure that all patients are receiving care according to the same standard across the country. Defining standards will be particularly important when the new medical complex in Georgetown with dialysis is operational. These guidelines could also outline the appropriate prescription practices that line up with the availability of drugs on the Saint Vincent Essential Medicines List (EML).

Creating these guidelines will require establishing a committee to first review best practices and guidelines used in other countries and to determine the appropriate standards for Saint Vincent. The committee would also need to create a policy for periodic revision and roll-out to facilities. The guidelines should identify the responsibility of each level of care and establish referral criteria and mechanisms for follow-up care. The SVG Dental and Medical Association, along with civil society groups

like the Diabetic and Hypertensive Association, could spearhead this effort with guidance from the CMO.

5.6.2 LONGER-TERM RECOMMENDATIONS

Promote the use of rural hospitals and health clinics

Many patients are self-referring to MCMH, putting a strain on the A&E department for primary care issues. Many patients are willing to make the trip further away for the convenience offered at MCMH. The opening of the Stubbs Polyclinic should help reduce this burden by drawing patients to the polyclinic facility rather than to MCMH. However, a sustained effort to promote the use of the district facilities would benefit the entire system. The MOHE should encourage users to take advantage of the services available at the health clinics and district hospitals. A number of strategies could be used to address this problem including the following:

- Improved maintenance of equipment at the rural facilities would ensure that services that can be offered at this level are available. Improved maintenance of the lab vehicles would also help to reinstate pick-up of samples at the district hospitals
- Stronger enforcement of user fees at MCMH or the introduction of higher fees for primary care provided at MCMH could deter some patients from seeking primary care at MCMH
- Initiation of a public awareness campaign could help define appropriate levels of service for care-seeking

Implement supportive supervision which can support quality improvements and provide feedback to health facility staff

Saint Vincent has a supervision structure in place, but it seems to function mostly as a reporting mechanism rather than as a system to identify and address issues around the quality of care. Supportive supervision promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, helping to optimize the allocation of resources, and promoting high standards, teamwork, and better two-way communication (PATH Children's Vaccine Program 2003). Currently, supervisors have checklists to ensure clinical standards are met, but the assessment did not find channels for corrective action or feedback on progress made. Supportive supervision would establish goals, monitor progress, and address problems identified to improve the quality of service.

6. HUMAN RESOURCES FOR HEALTH

Key Findings

- Saint Vincent has a solid, consistent nurses' training program that produces a surplus of health workers
- The human resources component of SmartStream is currently underutilized. This is being addressed using external assistance
- Extensive training for health workers has resulted in widespread capacity for providing VCT
- Legislation governing health professions provides basic guidelines on licensing, but needs strengthening in guidance on education and re-licensing
- Procedures for replacing departing staff are cumbersome and time-consuming
- An HRH strategic plan has not yet been developed or implemented, though it was identified as a need in the Strategic Plan for Health
- Dual practice among physicians is largely unregulated, resulting in perceptions by the private sector that a subsidization of private practice for some providers takes place

WHO's World Health Report 2006 (WHO 2006) defines HRH, or the health workforce, as: "all people engaged in actions whose primary intent is to enhance health." These workers also include "those who promote and preserve health as well as those who diagnose and treat disease. Also included are health management and support workers – those who help make the health system function but who do not provide health services directly" (WHO 2008b). Aspects of HRH that are generally considered urgent include shortages of health care workers on a national scale and a misaligned distribution of health care workers, especially between urban and rural areas.

WHO recommends that national governments engage in a multisectoral process to create an enabling environment for HRH and human resources management (HRM). These recommendations are presented as the WHO Global Health Workforce Alliance HRH Action Framework and cover such areas as policy, finance, HRM, education, partnership, and leadership (WHO 2011b). Central to meeting HRH needs is the development of strong HRM at all levels of the health care system. HRM may be expressed in terms of:

- Planning the workforce
- Developing the workforce
- Managing the workforce

In Saint Vincent, the MOHE has recognized the need to strengthen planning and management of the health workforce and has taken action to:

- Develop HRH plans
- Secure assistance in HRH capacity building (primarily from the EU and the World Bank)
- Assess a core dataset of human resources information with PAHO assistance
- Produce a description of the regulatory framework
- List existing human resource development opportunities, such as pre-service and in-service training.

6.1 HUMAN RESOURCES PROFILE

According to the PAHO Essential Public Health Functions assessment conducted in 2008, no HRM and development policy exists in Saint Vincent. A human resource plan was contemplated for implementation in 2007 as part of the Strategic Plan for Health, but the plan was never developed. Additionally, neither compilation of absolute numbers nor the distribution of health workers resulted from a planning process. A European Commission report from 2010 noted that:

“...there is no method or tool used systematically to forecast the demand for new and replacement Human Resources for Health. No succession planning for one-of-a-kind health workers is in place. The health sector authorities continue to respond to staffing gaps, across all service levels, in an ad-hoc way.” (Gillespie and Nielsen 2010)

One of the main challenges facing the health system in Saint Vincent is the appointment of personnel. Estimates of the interviewees from this assessment were that roughly 10 percent of all funded positions have not had health workers appointed to fill them. Many empty senior positions were filled by civil servants who were working in an “acting” capacity. Filling vacant posts, even for less-senior positions like staff nurse, requires a lengthy process that can take up to one year. In addition, poor succession planning for long-serving incumbents also threatens the long-term sustainability of certain aspects of the health system, including specialist doctors.

6.2 HEALTH POLICIES

The Strategic Plan for Health notes that data on human resources in Saint Vincent is not well organized and that staff shortages exist in specialist areas such as physiotherapy, social work, and radiography. In the logical framework attached to the Strategic Plan for Health, HRH objectives were developed, including developing a Human Resources Information System (HRIS), writing an HRH strategic plan, and ensuring that all vacant positions are filled. While the Strategic Plan for Health does not provide the necessary guidance for achieving these goals, it does provide indicators to measure success. Currently, progress is being made on implementing an HRIS (called SmartStream); however, there has been little progress toward developing an HRH strategic plan. Though there have been no structural changes to fill vacant positions, the CNO did note that she had recently persuaded the MOF to allow the SCD to fill a number of vacant staff nurse positions. Even though these staff nurse positions have been released by the MOF, approval was not given by the SCD for a number of management positions, leaving them unfilled.

In the absence of a strategic plan for HRH, staffing patterns are largely historical; percentage increases in budgets guide what new staff members are hired, rather than an analysis of need. As human resource functions for the government are located in the SCD, the MOHE's role in HRM is often advising the SCD and guiding existing staff. No staff person at the MOHE has the primary role of guiding human resources-related issues within the health sector. Rather these functions are split between the CNO, the CMO, and the Health Planner. Despite these challenges, some progress has been made on improving regulation of the health sector, as the Pharmacy Act was passed into law in 2004, and the Medical Act, Nurses and Midwives Act, and the Pharmacy Act Regulations are in various stages of completion. Once enacted, these updates will provide for licensure, registration, continuing education, and enhanced disciplinary procedures. The Medical Act and the Pharmacy Act Regulations, however, continue to be stuck at the legal affairs office, a situation that has persisted for years.

In addition to general practice legislation, regulations on public sector physicians who have private medical practices (referred to as dual practice physicians) are not clear. Currently, the government regulates dual practice by putting a clause in the contracts of senior doctors. In Saint Vincent, there are

five levels of doctors (from lowest to highest level of experience): Intern, Medical Officer, Registrar, Senior Registrar, and Consultant. Only those physicians classified as Registrars and above are allowed to be in dual practice, while the amount of time permitted to be spent at a private practice increases with seniority. In theory, these senior doctors attend rounds with junior doctors at MCMH in the morning and then go to their private practices in the afternoon. In practice, however, the amount of time that dual practice physicians *must* work at MCMH is not defined in their contracts. Interviewees noted that some consultants work only about two hours at MCMH before going to their private practice, although they are some of the highest-paid staff in the civil service.

6.3 HEALTH WORKFORCE

6.3.1 DISTRIBUTION OF HEALTH WORKERS

As of 2010, PAHO estimated that Saint Vincent had 923 public sector health care workers. These figures are presented by PAHO occupational category, with health-related worker density per 10,000 people and the number of people in Saint Vincent per HRH worker in Table 6.1.

TABLE 6.1: PUBLIC SECTOR HUMAN RESOURCES FOR HEALTH WORKERS PER 10,000 POPULATION BY PAHO OCCUPATIONAL GROUPINGS

Occupation	Number of Workers (%)	Density per 10,000 Population (95% CI)	Population per Worker
Medical doctors	62 (6.7)	5.84 (4.47–7.48)	1,714
Nurses and midwives ^a	268 (29.0)	25.22 (22.29–28.43)	396
Nursing assistant/auxiliary/aide ^b	208 (22.5)	19.58 (17.01–22.42)	511
Nursing assistant	127 (13.8)	11.95 (9.96–14.22)	837
Nursing auxiliary	41 (4.4)	3.86 (2.77–5.23)	2,592
Nursing aide	40 (4.3)	3.76 (2.69–5.13)	2,656
Dentists and allied	21 (2.3)	1.98 (1.22–3.02)	5,060
Pharmacists and allied	23 (2.5)	2.16 (1.27–3.25)	4,620
Social workers	12 (1.3)	1.13 (0.58–1.97)	8,854
Rehabilitation workers	5 (0.5)	0.47 (0.15–1.10)	21,251
Technologists	24 (2.6)	2.26 (1.45–3.36)	4,427
Public health practitioners	67 (7.3)	6.31 (4.89–8.01)	1,586
Nutritionists	8 (0.9)	0.75 (0.33–1.48)	13,282
Mental health practitioners	1 (0.1)	0.09 (0.00–0.52)	106,253
Other health workers	224 (24.3)	21.08 (18.41–24.03)	474
ALL health workers	923 (100.0)	86.87 (81.35–92.66)	115

Source: PAHO (2010b)

^a Nurses and midwives have the same occupational groupings in the government payroll system.

^b The nursing assistant is a trained professional that is required to register with the nursing council in order to practice. Nursing auxiliaries are not trained and are not required to register with the nursing council; they assist with general ward activities. The nursing aide is also not trained or registered.

In the public sector, there is one doctor for every 1,714 Vincentians. With 268 nurses and midwives in the public health system (a density of 25.2 per 10,000) there is one nurse for every 396 Vincentian and roughly four nurses for each doctor. In Saint Vincent, three further categories of nursing staff exist: the nursing assistant, the nursing auxiliary, and the nursing aide. The nursing assistant is a trained professional that is required to register with the nursing council in order to practice. Nursing auxiliaries are not trained and are not required to register with the nursing council; they assist with general ward activities, such as taking samples to the laboratory. The nursing aide is also not trained or registered, but assists individuals living at the Mental Health Rehabilitation Center and the Lewis Punnett Geriatrics Center with activities of daily living. There are a total of 208 nursing assistants, nursing auxiliaries, and nursing aides in the Saint Vincent public sector health care system, adding up to a density of 19.6 nursing

professionals per 10,000 people or one for every 511 Vincentians. A fourth major category, other health workers, includes the many health managers and support workers involved in maintaining health care and health care facilities; there are 21.1 other health workers per 10,000 people (PAHO 2010b).

There are 25.2 nurses for every 10,000 people in Saint Vincent, which is roughly twice the number of nurses per capita as a selection of CARICOM countries included in a recent World Bank study (World Bank 2009). In fact, the supply of staff nurses and midwives currently exceeds demand, as approximately 50 nurses are waiting to fill posts, leading to an estimated unemployment rate of 20 percent for nurses in Saint Vincent. Interviewees noted that the Saint Vincent and the Grenadines Community College School of Nursing trains more nurses than can be accommodated in the public health system as a deliberate poverty alleviation strategy and that nurses who were unable to find work in Saint Vincent were expected to migrate abroad. Therefore, the major challenge appears to be rationalizing the number of public sector nurses needed, rather than a true shortage of the total number of nurses in Saint Vincent. These challenges contrast sharply with the situation in other OECS countries which face shortages in the training of nurses locally.

Additionally, Saint Vincent is a net exporter of nurses to health care systems in other Caribbean countries and the United States, Canada, and the United Kingdom. While there is an oversupply of nurses in Saint Vincent, there are also serious deficits in several categories of auxiliary workers. For example, there are only nine staff people in the entire health education department to fill both central- and district-level positions, even though each of the nine districts is supposed to have one health educator. The educator post in the Southern Grenadines, for example, has been unfilled for the last two years. Additionally, there are no dietitians at either MCMH or the Lewis Punnet Geriatrics Center to monitor the nutrition of patients in residence (Gillespie and Nielsen 2010).

Other shortages of health workers include environmental health workers, who enforce food safety regulations, skilled maintenance staff, and specialist doctors. As the available pool of human resources on Saint Vincent is quite small, succession planning is a significant need which has not yet been fully considered. The European Commission report gives the example of the Assistant Engineer at MCMH. He has held his post for 14 years, and a Senior Engineer, who would supervise this post, has never been hired. In effect, the Assistant Engineer performs both jobs (Gillespie and Nielsen 2010).

Specialist doctors are also at a premium: there are no cardiologists, oncologists, nephrologists, or endocrinologists in Saint Vincent, and only one radiologist. One specialty that appears to be well staffed is obstetrics and gynecology. As the requisite experience for other specialists does not exist on Saint Vincent, the new dialysis center in Georgetown is currently slated to be staffed for the first two years by Cuban health workers, with the idea that Vincentians will be trained to use the equipment by the Cuban staff. The oversupply of generalist nurses, rationalizing nursing training and the shortage of specialists, particularly in relation to new facilities such as the dialysis center and the paediatric wing of MCMH, highlight the need in Saint Vincent to develop an HRH strategic plan.

6.3.2 DISTRIBUTION BY LEVEL OF CARE

Table 6.2 presents health care workers in three types of facilities: health centers, rural hospitals, and MCMH. Health centers and rural hospitals provide primary care services, while MCMH is the sole secondary and tertiary care facility in Saint Vincent. These three types of health facilities are the main employers of clinical doctors and nurses, with few doctors being employed entirely in the private sector.

The distribution of health workers is heavily skewed toward tertiary care, with 90 percent of doctors and 55 percent of nursing staff being employed at MCMH. MCMH also employs the largest share of the entire MOHE workforce (51 percent of 923 total workers). The seven doctors that work at the primary level divide their time between various primary care facilities, including the rural hospitals and health

centers, often spending one morning per week at each health center in their district and afternoons at the rural hospital.

TABLE 6.2: HEALTH WORKERS IN PRIMARY, SECONDARY, AND TERTIARY CARE

Health Care Facility	Number	Density per 10,000 People	Population per Worker
Primary care: health centers			
Doctors	7	0.66	15,179
Nurses and nurse assistants	161	15.15	660
Primary care: rural hospitals			
Doctors	-	-	-
Nurses and nurse assistants	52	4.89	2,043
Secondary/tertiary care: MCMH			
Doctors	54	5.08	1,968
Nurses and nurse assistants	262	24.66	406

Source: PAHO (2010b)

6.3.3 PUBLIC VS. PRIVATE

It is difficult to get a full accounting on the number of doctors completely in the private sector because of the prevalence of dual practice and the absence of an authoritative central provider registry. Table 6.3 shows the breakdown of health workers in Saint Vincent between private and public sector. There seem to be an estimated 42 doctors currently working in both the public sector and the private sector, which accounts for essentially half of all doctors and the majority of public sector doctors (PAHO 2010b). Interviews conducted for this assessment supported these estimates. When asked how many public sector doctors also practice in the private sector, the response from interviewees for this assessment was usually “all of them.”

Among the private practitioners interviewed, there is a sense of unfairness that dual practitioners have the advantage in carrying out a lucrative medical practice in Saint Vincent, since business risk and financial investment are much lower for dual practitioners than for providers operating purely in the private sector. Also, private sector physicians are limited in growth because regulations do not allow them to use public hospital facilities for surgery and no private surgical facilities currently exist, thus limiting the scope of private practice on the island to nonsurgical activities. There is also the sense among the doctors interviewed that dual practice physicians can offer lower prices, attracting clients away from a purely private sector practice. According to some private providers, dual practice physicians can afford to lower their rates, as they receive a base salary from the MOHE. This dynamic may be inadvertently subsidizing certain private health services by offering rates that do not completely reflect the cost of doing business and which undercut (purely) private sector providers who must bear the full cost of their practices.

Interviewees also noted that essentially all registrars, senior registrars, and consultants maintained a private practice. Interviews with the Nurses Association showed that very few nurses were in the private sector; those that were had been employed by the private Maryfield Hospital before it closed. Approximately 50 nurses, however, are unemployed as they wait for appointment in the public sector or positions abroad. Pharmacists, much like doctors, also showed a high degree of dual practice. Though the numbers for pharmacists do not reflect much dual practice, in interviews, pharmacists noted that they spend spare time after finishing work in their public sector day jobs working at private pharmacies.

TABLE 6.3. HEALTH WORKERS REGISTERED WITH THE REGISTRATION COUNCILS^a IN SAINT VINCENT BY OCCUPATIONAL CATEGORY

Occupation	Number in Public Sector	Number Registered	Active Members ^b	Estimated Full/Part-Time Private Sector Workers
Medical doctors	-	109 ^b	95 ^c	42 ^d
Dentists	-	25 ^b	25	13
Nurses/nursing assistants	-	1,104/273	558/210	unknown
Pharmacists	22	49 ^e	42	20

Source: PAHO (2010b)

a The General Medical Council, the General Nursing Council, the Pharmacy Council, and the Paramedical Council

b Number obtained from SVG Medical Association

c Six are working abroad

d From Yellow Pages

e Seven are students

6.4 HUMAN RESOURCE DEVELOPMENT

Management of the health workforce in Saint Vincent is the joint responsibility of the SCD, the MOHE, and the MOF. The SCD is the government agency responsible for the entire government workforce, including all government health workers. In this role, it oversees appointments, training, scholarships, disciplinary measures, and payroll. The MOHE, as the ministry responsible for health in general, recommends appointments to positions, informs the SCD about vacancies, and oversees ongoing training. The MOF manages the payroll budgets for health workers and releases positions as funding becomes available.

6.4.1 HUMAN RESOURCES INFORMATION SYSTEMS

Information on human resources in the health sector is currently managed in alignment with other ministries, except for the SCD. The SCD conducts performance reviews, develops job descriptions, and coordinates training and educational opportunities. These management tools are often not shared between the SCD and the MOHE. Currently, much of this information is paper-based, though two computer-based systems are currently under development to provide data and analysis tools for the existing public health workforce.

The first system under development falls under the purview the SCD and the World Bank's Electronic Government for Regional Integration Project (E-GRIP). This project is implementing SmartStream management software throughout the entire public sector, which has the capability to manage finances, human resources, assets, and performance management. As the software is modular, the government of Saint Vincent has decided to stagger the implementation of different modules; currently, the SCD is managing payroll for the entire public service using SmartStream. The government has already purchased the human resource module and plans to expand the use of SmartStream to include other human resources functions, such as education, experience, and time in post.

The second electronic HRM system under development is specific to the MOHE and is a module of the new electronic HIS (SVGHIS) that is being rolled out by the HPIU. According to interviewees, the human resources component of the SVGHIS is not a priority for the HPIU; however, the work being done by the SCD and the MOHE will need to be coordinated in order to avoid duplication of effort.

6.4.2 RECRUITMENT AND ABSENTEEISM

The recruitment process for health workers in the public sector is circuitous and bureaucratic, in some cases taking up to one year to fill open positions, depending on the amount of vacation time the incumbent has accumulated. First, the MOHE must notify the SCD of the resignation and the SCD must officially accept the resignation. Next, all vacation time accumulated by resigning workers must expire before the MOF will allow the SCD to hire a replacement. Once all the vacation time has expired, the MOHE must request the MOF for approval to fill the position and the MOF must release the position by allowing the SCD to begin the process of finding a replacement. Finally, the SCD, with advice from the MOHE, advertises and places a new hire in the position. Additionally, workers are often placed in acting positions by the SCD in order to evaluate their fitness for the role once it is released by the MOF and the SCD can begin the hiring process.

The length of time it takes to fill positions puts a strain on the health workforce; during the assessment, an interviewee estimated from their data that roughly 15 percent of nursing positions were unfilled as a result of delays in the hiring process. Most health workers in positions are Vincentians and retaining workers did not seem to be a significant challenge as Saint Vincent. There is an oversupply of nursing staff in Saint Vincent, which make up the bulk of health professionals in the country.

Absenteeism was noted as a significant challenge in the 2010 EU Feasibility Study which stated, “absenteeism and attrition are commonplace amongst the Nursing Aides and Ward Attendants...absent is an *esprit de corps* at MCMH due to rapid, frequent turnover of lower-tier staff” (Gillespie and Nielsen 2010). The USAID-funded HSA found that while long-term absenteeism was not a significant problem, short-term absenteeism that did not require a doctor’s note was identified as a frequent problem. Ward Sisters at MCMH recognize short-term absenteeism as an impediment to providing quality care. In fact, they have produced a report outlining the number of absences taken by nursing staff, their on-time arrival percentage, and when tardiness and absences occurred. They found that all cadres of nurses were disproportionately more likely to take short-term sick leave on Monday, which points to inappropriate use of sick leave benefits. While these managers did not have the disciplinary authority or the ability to provide incentives, they brought the information to the attention of the nursing staff, in order to give them a sense of the problem.

In addition to absenteeism, long vacations are problematic for ensuring that enough staff are available to meet patient demand. Since most public sector workers get 30 days of vacation, multiple workers, often doctors, tend to take vacation at the same time. Rotating staff between MCMH and community health facilities compensates for the absence of these health workers, but ensuring that all needs are met is often a difficult proposition.

6.4.3 SUPERVISION

Supervision of health workers is an important aspect of HRM. In Saint Vincent, nursing and medical staff have separate reporting lines, with the CNO and the CMO overseeing the respective professions. Nursing is further broken down into Community Health and MCMH; each of these areas also has Ward Sisters (Charge Nurses) who directly supervise the Staff Nurses. In the staffing plan, Ward Sisters oversee each of the Rural Hospitals and the nursing services on each ward at the hospital. Currently nine nursing management positions, such as Ward Sisters, are unfilled. These managers set schedules and provide technical oversight of the work performed on their wards; however, they do not have any HRM functions, including the ability to discipline or hire employees. For these functions, managers must go through the SCD. Doctors operate more independently than nurses, with senior doctors, such as registrars and consultants, overseeing the work of junior doctors, such as interns and medical officers. All medical services throughout the Saint Vincent health system are supervised by the CMO.

For new nursing staff, the Procedure Manual for Community Nursing is a resource for learning standard operating procedures. This document dates to 2002 and is currently under revision by the Community Nursing Office. Additionally, all staff members have job descriptions that are on file with the SCD and in the possession of the health worker. Performance appraisals are done once a year and are used to determine promotions. Staff members have access to them and ask for them when they are being considered for promotions. The highest authorities on managing medical, nursing, and pharmaceutical professions in the country are the appropriate councils, which oversee registration, academic qualifications, and disciplinary sanctions for their respective domains.

6.5 WORKFORCE DEVELOPMENT

6.5.1 PRE-SERVICE EDUCATION

Despite the small size of Saint Vincent, training opportunities for medical and nursing professionals do exist. Nursing education can be obtained at the government-operated Saint Vincent and the Grenadines Community College School of Nursing, which was moved from the purview of the MOHE to the Ministry of Education in 2009. The program at this school leads to an Associate's Degree for registered nurses, and certificate programs for midwives and nursing assistants exist as well. In 2009, there were 166 places for registered nurses and 25 for nursing assistants, with all places filled. Twenty midwifery slots were not filled.

As Saint Vincent does not have an on-site, fully accredited four-year university, specialisation within nursing can be secured only from Faculties of Nursing in the larger Caribbean countries, in Europe, or in North America. Currently, nurses filling jobs in specialised MCMH divisions (notably the Operating Theater, Intensive Care Unit, and Trauma Unit) have learned to do so on the job, without benefit of a recognized qualification in that nursing speciality. This finding presents a challenge to meeting the standard criteria of a secondary hospital attempting to secure a form of recognized hospital accreditation in the future, which had been identified as a method for demonstrating quality and a stated objective of the Saint Vincent Strategic Plan for Health (PAHO 2008).

Medical education also exists in Saint Vincent, as an offshore medical school, Trinity School of Medicine, was established in 2009. At the time of the assessment, Trinity School of Medicine noted that the school had 9 Vincentians in the pre-Medical program, 13 in the Medical program, and 7 in clinical rotations in the United States. The school also has a scholarship program to train Vincentian doctors, offering one full scholarship for a Vincentian student and a reduced tuition rate for all Vincentians.

As the Trinity School of Medicine is quite new, most current doctors in Saint Vincent were trained at University of the West Indies (UWI), St. George's University in Grenada, or at institutions in Venezuela and Cuba. The PAHO core dataset indicates that for the 2006–2007 academic year, eight citizens of Saint Vincent applied to any kind of medical degree program and one was accepted. For the 2007–2008 academic year, 18 applied and 9 were accepted. From 2003 to 2006, no Vincentians graduated from any UWI health training program (PAHO 2010b).

In order to facilitate access to medical education, the SCD has a number of scholarships available for study at UWI, while St. George's University has historically offered scholarships to Vincentian students. For the Latin American School of Medicine in Cuba, the SCD shortlists applicants who have passed at least two A-level subjects, preferably in the sciences (PAHO 2010b). The Cuban government makes the final selection. Last year there were 50 applicants in a range of subject areas, both medical and nonmedical, and 19 scholarships were awarded by the SCD (PAHO 2010b). For scholarships based in Venezuela, interviews are conducted at the local embassy. The Cuban and Venezuelan options require the applicant to learn Spanish upon arriving, as it is the language of instruction.

6.5.2 IN-SERVICE EDUCATION

In-service training is organized by the Medical Director at MCMH every Wednesday at 1 PM. For nurses, the training covers a range of topics, including clinical care and management skills. Often lecturers from the Trinity School of Medicine provide these seminars. Additionally, an annual symposium provides an opportunity for medical professionals to hear from overseas experts on areas of interest.

Though continuing education is not a requirement for any health professional, there has been movement toward making it mandatory. For example, the Nurses Association would like to require that members attend a certain number of continuing education sessions before they are allowed to re-register.

Pharmacists noted that while the Pharmacy Act does not require continuing education credits to re-register, the Pharmacy Act Regulations will give the Pharmacy Council the authority to set a number of required hours and deny registration to pharmacists who do not obtain the required number of credits. These regulations are currently in draft form and are not yet enacted into law.

6.6 RECOMMENDATIONS

6.6.1 SHORT-TERM RECOMMENDATIONS

Streamline the hiring process through statutory reform or updating guidelines

The process for hiring new staff throughout the entire public service is bureaucratic and time-consuming. Reforming the process to improve the timeliness of replacing departing staff would go a long way toward relieving some of the burden on current staff. Some specific ideas for consideration include: providing a lump sum payment to retirees for their vacation time, limiting the amount of vacation time that civil servants can accrue, and devolving the authority to hire certain levels of health workers (such as nurse assistants) to the MOHE.

Coordinate with the Service Commission Department to clarify the roles of each Human Resources Information System (SmartStream and SVGHIS) in managing human resources in order to avoid duplication

As noted, both the SCD and the HPIU at the MOHE are developing HRIS functionality in their respective databases. Coordinating between the SCD and the MOHE to determine if there is overlap between the two systems and how they could collaborate, rather than compete, would promote efficiency.

6.6.2 LONGER-TERM RECOMMENDATIONS

Develop and implement a Human Resources for Health strategic plan

One of the key indicators for the current Saint Vincent Strategic Plan for Health is the development of an HRH strategic plan. Currently, there is no operational HRH strategic plan to guide investments in human resources. This type of guidance is sorely needed to provide more depth to the broad concepts outlined in the Strategic Plan for Health, adjust health worker training to meet demand, and rationalize the appropriate placement of health workers.

Rationalize nurse training needs to match demand

Currently, more nurses are being trained than can be employed in the public sector, and private employment opportunities are almost nonexistent for nurses. As a result, many nurses are unemployed or have to go abroad for employment. As nurses' training is provided free of charge by the government of Saint Vincent, there is no opportunity cost for prospective nurses to go into training. When those nurses are not hired by the government, either by staying unemployed or going abroad, the government does not benefit from their training through improvements in access to health care. Fully understanding

the costs and benefits associated with the oversupply of nurses would help the MOHE rationalize the system as a part of an HRH strategic planning process. Additionally, the need to train more specialist nurses remains acute and should be considered during planning.

Update legislation on health providers to include a continuing education requirement, regular licensing, and improved disciplinary procedures

Regulating the practice of health providers is a key governmental role. As with other pieces of legislation that are stalled, better coordination with the Attorney General's office would help substantially. See Chapter 3, Governance for more details about improving the legislative environment.

Clarify the responsibilities of public sector doctors who have private practices

As noted above, the written agreement between senior doctors and the SCD states that senior doctors can have private practices. However, many doctors interviewed expressed frustration that few regulations governed how these doctors should spend their time. It was felt by a number of physicians interviewed that dual practice is underregulated and not always geared towards improving health. While dual practice is a part of the health system in Saint Vincent due to its importance in supplementing the salaries of public sector doctors, stronger guidelines and regulation on dual practice would provide useful guidance. For instance, the government could mandate a set number of hours that dual practice physicians must work for the public sector.

7. MANAGEMENT OF PHARMACEUTICALS AND MEDICAL SUPPLIES

Key Findings

- Affordable pharmaceuticals are available due to discount bulk-buying through the Pharmaceutical Procurement Service (PPS)
- Recent investments in pharmacovigilance, lab strengthening, and the creation of an EML are improving the management of pharmaceuticals and medical supplies
- Legislation for the pharmacy sector is in place but lacks an enforcement mechanism, namely regulations to the Pharmacy Act
- Access to medications for mental health patients attending community-based clinics has decreased, as nurses may no longer dispense in accordance with the Pharmacy Act
- Limited training on ARVs for pharmacists at the MCMH has resulted in inappropriate medications being prescribed to PLHIV
- Stock-outs (particularly aspirin, antidiabetics, injectable medications, and standard consumables such as latex gloves) are common at multiple levels and have been attributed to cash flow problems impeding procurements, poor inventory management in the districts, and wastage of medications in the hospital wards

Careful management of pharmaceuticals and other medical products is essential to meeting health system goals. Even so, many health systems and programs run into difficulty achieving their goals because they have not addressed how the medicines essential to saving lives and improving health will be managed, supplied, and utilized. Pharmaceuticals can be expensive to purchase and distribute, but shortages of essential medicines, improper use of medicines, and spending on unnecessary or low-quality medicines also have a high cost – wasted resources and preventable illness and death. Pharmaceutical management represents the whole set of activities aimed at ensuring the timely availability and appropriate use of safe, effective, quality medicines and related products and services in any health care setting. Due to the increasing prevalence of chronic NCDs in Saint Vincent and the anticipated reduction in external financial support for ARVs, proper management of the sector is a vital for the financial sustainability of health systems in the country.

7.1 OVERVIEW OF THE MEDICAL PRODUCTS MANAGEMENT SYSTEM

According to several stakeholders interviewed for this assessment, pharmacists in Saint Vincent have traditionally been a first-stop for patients seeking medical advice, whether it be for a specific medication or to see if they really need to see a doctor. Medicines in Saint Vincent are supplied through 40 government pharmacies (located at a health clinic or district hospital) and 17 for-profit retail pharmacies (Pharmacy Council 2011). The public sector pharmacies are allocated such that each district has two to five pharmacies, but these pharmacies do not operate on a daily basis (PAHO 2010a). District health clinics and district hospitals often operate only one day a week when the pharmacist is on rotation at that clinic/hospital. The pharmacy at MCMH operates daily. There were 17 licensed pharmaceutical

importers in 2009 (Inter-American Drug Abuse Control Commission [CICAD] 2010) and seven registered wholesalers of pharmaceutical products in 2011 (Pharmacy Council Registry 2011). There are no pharmaceutical manufacturers operating in Saint Vincent. As of 2011, there were 49 registered pharmacists across Saint Vincent and the Grenadines. The public sector employs approximately 24 of these pharmacists (WHO and the Global Fund 2011). There are also two additional registered pharmacist assistants. Registered nurses have recently been prohibited from dispensing prescriptions to mental health patients in community clinics, further hindering access to medications for some patients.

The escalating costs of medicines, increased financial constraints, and the increased burden of chronic NCDs in Saint Vincent has forced the country to look for more efficient procurement, management, and distribution systems for medicines to increase accessibility (OECS 2011a; MOHE 2007). Finding lower-priced medicines challenges a country with a small population because there are limited economies of scale in purchases. To increase efficiency, Saint Vincent participates in the OECS's PPS. The PPS has assisted all OECS countries in reducing the cost of procuring medicines and has also provided more rigorous regulation and oversight of procurements. The PPS plays a critical role in ensuring access to medicines in the public sector.

The Pharmacy Act of 2002 sets most of the policy governing the pharmaceutical sector in Saint Vincent. More recently, the EML was released in September 2010 (MOHE 2010a). The Pharmacy Act provides for the regulation and control of pharmaceutical practice and related matters and also provides for a Pharmacy Council to regulate standards and practices for all pharmacists, pharmacies, and pharmacy owners. The EML is modeled to guide purchases and prescription in the public sector. Under the Pharmacy Act, pharmacy owners/operators are not permitted to dispense drugs without a licensed pharmacist in attendance (PAHO 2010a). The current law concentrates on the regulation of the pharmacist profession and not the regulation of the drugs themselves. In 2007, the Pharmacy Council submitted amendments to the Pharmacy Act to specifically address licensing for pharmacies, pharmacists, and drug wholesalers. The current law only calls for registration of pharmacies and pharmacists. However, personnel turnover at the Attorney General's office has resulted in delays in the completion of this review. Additionally, the regulations for the Pharmacy Act, providing specifications for the act's implementation, have not been passed.

The authorities responsible for coordinating activities related to the control of pharmaceutical products are the CMO and Drug Inspector in the MOHE, and the Saint Vincent and the Grenadines Pharmacy Council, which is responsible for handling the registration of entities, such as pharmacists and pharmacies, and drugs (CICAD 2010). The Pharmacy Council follows the U.S. Food and Drug Administration's Prescription Drug Product List to determine control of drugs and pharmaceuticals. The Drug Inspector carries out most of the daily regulation functions on behalf of the MOHE and reports to the CMO, who is officially charged with oversight. Currently, the Drug Inspector's role is limited by staff constraints. The inspector primarily monitors narcotics and private sector practice. The Pharmacy Act gives oversight of the registration of drugs to the Pharmacy Council; however, the council does not have the skill set or resources to follow through and has been exploring possibilities of more regional cooperation for regulatory oversight and the registration of drugs. The medicine regulatory function is largely done through the OECS PPS where public medicines are purchased through prequalified suppliers and where sample testing is conducted. There is no separate regulatory body in Saint Vincent.

7.1.1 REGISTRATION AND REGULATIONS

The Pharmacy Act requires that all pharmacists and pharmacies be registered but does not require them to be licensed. Importers, distributors, and wholesalers are also required to be registered (CICAD 2010). Registration requirements for pharmacists include paying a fee, qualification from an institution recognized by the Pharmacy Council, and being of good character, though the law does not define this last item. The Pharmacy Act requires annual registration for pharmacists. Several interviewees reported

there being many dual practice pharmacists working in both the public and private sectors; however there are neither regulations governing this practice nor systems in place to track this activity.

Registration for pharmacies includes paying a fee and having a physical inspection conducted. A registered pharmacist must be present at all times of dispensing per the Pharmacy Act. The Pharmacy Act does not provide details on what the Drug Inspector must look for to approve a facility and older legislation provides limited guidance for the Drug Inspector to use. The initial inspection checklist focuses on whether due diligence was done hiring staff, fulfilling spatial requirements as well as security and construction specifications, and whether there is a process for filling out the stocks and prices of certain drugs, if requested. Pharmacies opened prior to the regulations that do not meet the Drug Inspector's requirements have been granted exemption. The Drug Inspector attempts to visit retail pharmacies at least twice a year and wholesalers once a year, but this plan is limited by staffing shortages. The public sector is inspected on a periodic basis. Interviews during the assessment found that inspections of pharmacies and distributors do take place. Under the Pharmacy Act, only doctors and pharmacists may import controlled substances. To qualify, doctors and pharmacists must acquire an import license and report regularly to the Drug Inspector on stock levels.

The Pharmacy Act currently does not have approved regulations to guide its implementation. The Pharmacy Council, in conjunction with the Pharmacy Association, drafted and submitted regulations based on best practices in 2006; however, the draft remains in the Attorney General's office. The regulations for pharmacists include continuing education requirements for licensure and exemptions allowing nurses in community health programs to dispense drugs under specific conditions without a pharmacist present. The regulation also looks at other issues related to pharmacies including regulation of internet and mail-order pharmacies and the regulation of the marketing and advertising of pharmaceuticals.

The assessment team found that the lack of approved regulations has resulted in a perception of politicization in the pharmaceutical industry. Interviewees from the private sector reported delays in approval for either a pharmacy or pharmacist registration for reasons they believed to be personal or related to party-affiliated politics. However, the official reasons cited largely coincided with provisions in the draft regulations that have not been formally approved. Without approved regulations, the Pharmacy Council and Drug Inspector lack the foundation to enforce the provisions outlined in the regulations. These provisions were designed to provide the highest quality care and safety of pharmaceuticals in Saint Vincent. The longer it takes for these provisions to be implemented, the more challenging it will be for the MOHE to ensure quality of the pharmaceutical sector in the future without the perception that politics are behind the changes.

According to several interviewees, starting several months prior to the HSA, the Pharmacy Act's provision that requires only registered pharmacists to dispense drugs began being enforced at the community mental health clinics. However, the unapproved regulations supporting the Pharmacy Act outline a process to permit nurses in this type of clinic to dispense medications with the proper training. The act allows nurses and doctors to administer drugs (i.e., to physically provide a needed dosage on the spot) but not to dispense (i.e., sell or give out future dosages). In the past, the nurses at the community mental health clinics would dispense medicines to patients as mental health patients were believed to be unlikely to follow up with a prescription at the pharmacy. The strict enforcement of the Pharmacy Act provision has forced the clinic to change its method of dispensing. Now each patient who is expected at the clinic has a package with the correct dosages made up at the Mental Health Rehabilitation Center pharmacy prior to the clinic. The packages are labeled with the patient's name and given to the patient. Unfortunately, this system does not allow for the nurses and doctors to dispense medication to walk-in patients. The mental health community reported feeling very concerned about the care that walk-in patients were receiving. A review of the unapproved Pharmacy Act Regulations indicated that these concerns have been addressed through a provision that allows nurses under certain

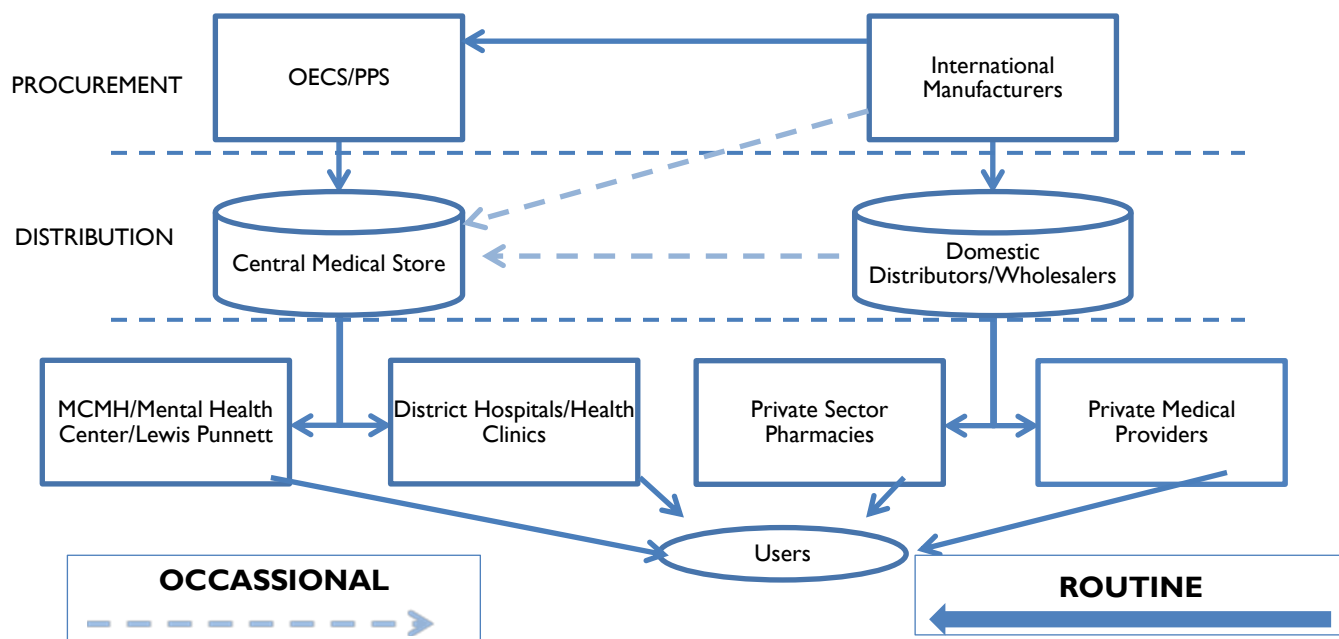
circumstances to dispense medicines with approval and training from the Pharmacy Council. Until these regulations are approved and a system is put into place, further dialogue between the pharmacy and mental health community is needed to address the care of mental health patients.

7.1.2 PHARMACOVIGILANCE AND ADVERSE DRUG REACTION

Pharmacovigilance is necessary to detect, assess, understand, and prevent adverse drug reactions (ADR). In Saint Vincent, there are no legal requirements for pharmacovigilance, but the country participates in the OECS's pharmacovigilance system which is an ad hoc reporting system, meaning the system relies on physicians and pharmacists to voluntarily report suspected ADR. The MOHE has recently invested resources in improving pharmacovigilance throughout the island, including appointing a pharmacovigilance officer. Throughout 2010 the pharmacovigilance officer sensitized approximately 154 nurses, doctors, and pharmacists in the public and private sector to the topic. All pharmacists interviewed for the assessment when asked reported that they had accessed or knew where to access the OECS forms for reporting ADR. The MOHE plans within the next year to expand awareness to the public to encourage reporting ADR and build public trust that those investigations will be conducted.

7.2 MEDICINES AND MEDICAL PRODUCTS SUPPLY

FIGURE 7.1: PHARMACEUTICAL SUPPLY CHAIN FOR SAINT VINCENT



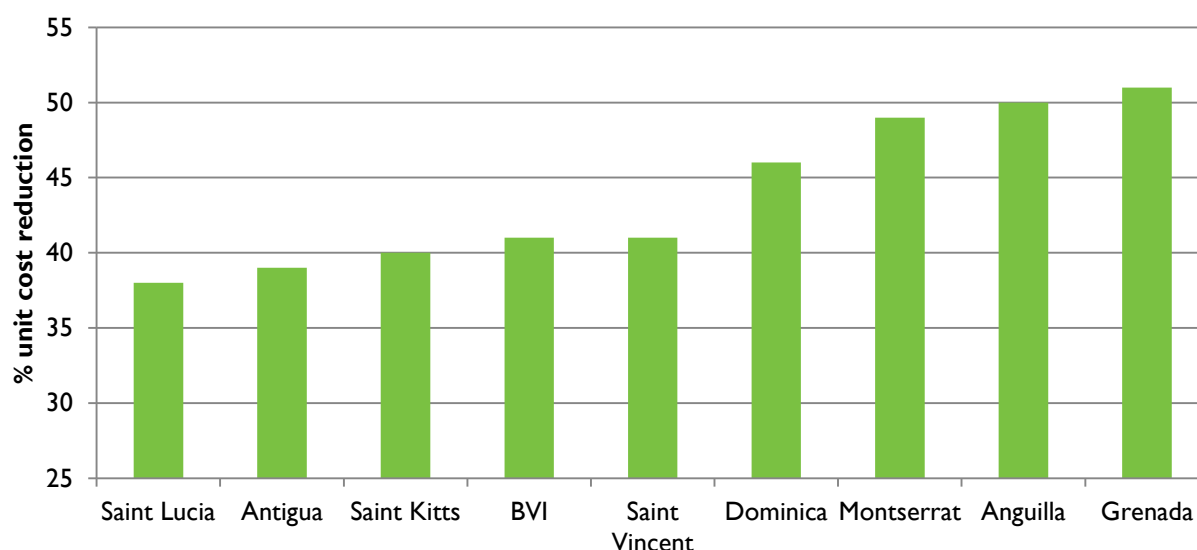
7.2.1 PUBLIC SECTOR SUPPLY

PUBLIC SECTOR PROCUREMENT

Pharmaceuticals in Saint Vincent's public sector are purchased through a centralized system. Largely, the Central Medical Stores (CMS) purchases through the OECS/PPS. The CMS orders from the PPS three times a year. The payment for orders is made through the office of the Permanent Secretary. Purchases outside of the PPS are often for products such as dextrose and IV solutions, and are largely due to supplier shortages or to withholding because Saint Vincent was late on its payment to the PPS. When the CMS goes outside of the PPS, it tends to use traditional suppliers (including some that the PPS generally uses) without a competitive bid process or testing of manufacturers. A local distributor can sometimes provide the items needed but there is no formal arrangement.

The OECS/PPS system, which has been in place since 1989, has reduced the cost of procuring drugs by approximately 30 percent annually for the region (Burnett 2009). As a result of the PPS purchasing mechanism, Saint Vincent has decreased its pharmaceutical costs significantly, averaging just over 40 percent reduction in costs for a basket of 20 popular drugs under one study (see Figure 7.2).

FIGURE 7.2: AVERAGE PERCENTAGE UNIT COST REDUCTION FOR A MARKET BASKET OF 20 POPULAR DRUGS 2001/02 VERSUS INDIVIDUAL COUNTRY PRICES



Source: OECS (2001)

However, Saint Vincent, along with several other countries in the region, is often late with payments that replenish the PPS account and allow the PPS to reimburse suppliers. These delays threaten the system by weakening PPS's position and thus raising the costs of goods it purchases and potentially reducing the quality of goods purchased. The suppliers view the whole region as a single block, so the late payment from one country can cause the suppliers to delay shipments to all the OECS countries, even if the others have balanced accounts. The OECS/PPS 2010 Annual Report noted that Saint Vincent had requisition orders suspended and that suppliers had withheld supplies due to delayed payments on orders.

Average availability of medicine in Saint Vincent was estimated to be 73 percent, the lowest performance on this indicator in the OECS along with Antigua and Barbuda (OECS/PPS 2011). Saint

Vincent has the longest lead time in days for payment of orders procured through PPS at 140 days (OECS/PPS 2011). This arrangement has resulted in suppliers threatening to impose interest charges on overdue invoices and some suppliers not submitting new tenders, reducing competition and increasing prices. Some interviewees noted their concern with lower-quality drugs coming into the public sector because the tendering process through the PPS attracted generics manufacturers in places like India while the private sector mostly sourced from more well-known companies in Europe or the United States. The drug quality concern is mitigated, however, by the prequalification of suppliers and sample testing done by the PPS.

Vaccines are procured through PAHO's Revolving Fund, which operate similarly to the PPS (Abbott and Bannenberg 2009). For the Revolving Fund, members contribute 3 percent of net purchase to a common fund as a line of credit for all members, which they must repay within 60 days of receiving the products (PAHO 2011). NAS in Saint Vincent orders ARVs directly from the CMS based on the number of registered cases. The Clinical Care Coordinator of NAS works directly with the CMS to place orders and the ARVs are then dispensed at MCMH.

The public laboratory at MCMH submits its purchase requests directly to the Permanent Secretary's office. The laboratory also controls the purchasing of laboratory equipment and reagents, neither of which is purchased through the PPS system. The laboratory budget is a part of the hospital budget not the pharmaceutical supplies budget, making it difficult for CMS to track procurements and spending specific to the laboratory. Late payments by Saint Vincent to the suppliers, both PPS suppliers and outside suppliers, have become acute recently, delaying delivery of shipments and leading to stock-outs of routine items such as reagents at the lab. According to stakeholders interviewed for the assessment, this problem is threatening routine testing, particularly for HIV. CD4 count tests in the public sector have been limited due to the outages, reportedly resulting in business moving to the private sector.

INVENTORY MANAGEMENT, WASTAGE, AND STOCK-OUTS

The CMS uses a software package called ORION@MSH to manage their pharmaceutical inventory. The CMS uses historical consumption patterns to forecast needs but this effort is challenging as they do not receive regular reports from pharmacies showing items received, disbursements to patients, and/or stock on hand. The CMS staff frequently does not know if the goods were consumed or left to expire. However, earlier this year the CMS created a form for recording the destruction of expired goods. Public pharmacies must submit this certificate which lists the type, quantity, and expiry date for the medicines. The SVGHIS currently being rolled out should allow the CMS to track the expiry dates of drugs and monitor pharmaceutical inventory more closely, as it contains a pharmacy module that pharmacies are being required to utilize.

All public pharmacies on the island use a pull system.³ The district pharmacists order for the district hospitals and clinics on a monthly basis. The pharmacies use bin cards to monitor their stocks, but recently the SVGHIS has been put in place for ordering from CMS. Unfortunately, at the time of the assessment not all pharmacies had computers or internet access in order to place their orders. According to interviews conducted, all pharmacies must use the electronic system for ordering, regardless of internet access. The pharmacies continue using the bin cards to monitor inventory. Each pharmacy has established a minimum supply that they should have on hand based on the expected demand, which is monitored by bin numbers or counts in the electronic system. Physical stock counts are supposed to be done when monthly orders are placed. The CMS delivers orders once a month. The

³ In a "pull" system, no commodities are sent unless requested. A "push" system would entail CMS sending out standard orders to facilities on a regular basis, unless the facility makes a special request for a nonstandard order.

CMS has one driver and two vehicles for delivery, which also pick up pharmaceutical shipments arriving at the ports.

While the PPS 2010 Annual Report noted that inventory management was satisfactory in Saint Vincent, a 2008 report noted that this was an area in need of capacity building (Munar 2008), and the team for this assessment similarly found that inventory management seemed to be a challenge, particularly at the district level. The district pharmacists are charged with overseeing the inventory for the district hospital (if there is one in the district) and for all of the health clinics. The district pharmacists do not have time to properly count their stock while they are rotating between clinics and seeing high volumes of patients at each clinic. They generally do not have enough down time at each facility to properly manage their inventory. Without counting stock, they do not have an efficient system to estimate how much of a product they are going through or what count they have in stock already. The recent move to electronic ordering is likely to provide improvements in stock management in the long term; however, the current lack of computers and consistent internet access at the clinics makes this ordering problematic. Some district pharmacists currently have to travel to Kingstown to use a computer. Pharmacists at MCMH, who have pharmacy assistants to help with inventory management, did not report as many challenges with stock-out issues as pharmacists at other facilities.

Key stakeholders interviewed noted wastage of pharmaceuticals at the hospital, although data to document the amount of wastage were not available to the assessment team. One pharmacist who was interviewed noted that nearly 25 percent of the inventory was lost because medications had expired. Interviewees also reported that doctors at MCMH often change medications, but that in these situations nurses do not always return the remaining unused medications to the pharmacy for proper storage. Instead the medications are left in the wards and often expire or become unusable due to clumping or cracking from exposure to the elements. Improper maintenance of the air conditioning and cold storage units in the district hospitals and clinics also threatens to create more wastage if not addressed.

For laboratories, interviewees noted that the maintenance of equipment is poor. Some equipment has been purchased outright without a service contract. Manufacturers often have specialized equipment that few technicians outside of their company know how to repair. In addition, the cost of bringing a technician to the island is usually prohibitive. Attempts have been made to increase the training that lab staff receive from the manufacturers when the item is purchased, but capacity for maintenance among the lab staff in Saint Vincent is still limited.

7.2.2 PRIVATE SECTOR SUPPLY

The 17 private pharmacies and 7 wholesale pharmacies play an important role in meeting the demand for pharmaceutical products in Saint Vincent. Public pharmacies outside of MCMH are not open on a daily basis and the private sector allows for patients to fill prescriptions at times more convenient for them, often with a shorter wait time. However, the pharmacies charge retail prices and not a flat fee of EC\$5 as in the public sector. Most of the private retail pharmacies and wholesalers are located in and around Kingstown but there are also retailers in other parts of Saint Vincent, including as far south as Union Island. The private pharmacy industry has grown rapidly over the past five years.

Private pharmacies provide a range of products that are not available in the public sector, especially for branded treatments, and over-the-counter medicines such as aspirin and ibuprofen which are sometimes out of stock or more expensive at the public health centers. The nonpharmaceutical products have become as important for these businesses as the prescribed drugs that they sell to bring business in the door. Some private pharmacies offer additional services on a regular basis, such as blood pressure screening. As businesses, they are focused on keeping clients, and this incentive manifests itself in offering competitive prices and emphasizing customer service. Customers help keep prices competitive across the private sector as well by actively comparing price information at various pharmacies before purchasing, particularly in Kingstown where private pharmacies are clustered close together.

While the practice is prohibited by the Pharmacy Council and the Pharmacy Act, interviews conducted indicate that some private providers offer pharmaceutical products through pharmacies attached to their practice or clinic (e.g., Mustique Clinic). The Planned Parenthood clinic offers contraceptive products which they source from Trinidad and supply to clinic visitors; they also supply pharmacies on the island with contraceptives. The top-selling products for all pharmacies were hypertensive and diabetes medications. ARVs were not routinely available at private pharmacies, but could be ordered through private pharmacies for clients that requested and paid for them directly. Stock-outs in the private sector were not common, although some retailers reported intermittent delays from the manufacturers that led to stock-outs. The retail pharmacies visited during this assessment found that there were both paper and electronic inventory management systems in operation.

Many retail pharmacies obtain supplies through local distributors or wholesalers. Private pharmacies rely on the drug registrations in other countries such as the U.S. and U.K. to ensure that drugs are safe since the drug registration mechanism in Saint Vincent, though it exists on paper, is not functional. Three distributors (Shepherd's, Coreas Hazells, and Brydens) represent some of the major international pharmaceutical lines, such as GlaxoSmithKline, Wyeth, Bayer, and Seven Seas. Wholesalers procure from a variety of locations including India, the U.S., Barbados, Trinidad, and the U.K. Importing pharmaceutical products is not a major impediment for business. It requires a specific import license, customs clearance, and a pharmacist's signature, provided the wholesale business is already registered. Both Coreas Hazells and Dasco have both wholesale and retail operations.

7.3 RATIONAL USE

Rational drug use is concerned with ensuring that patients are prescribed and dispensed the full amount of appropriate, high-quality medicines in a cost-effective manner and that the full course of the medication is completed without interruption. Policy for rational use in Saint Vincent has become more of a focus over the last few years. The Pharmacy and Therapeutic Committee was established in 2007 to establish the EML. The Pharmacy and Therapeutic Committee released a newly developed EML in September 2010. The EML is intended to guide purchases and prescriptions in the public health sector.

The EML Core List presents a list of minimum medicines that Saint Vincent deems necessary for the basic health care system usage, listing medicines for addressing its priority health conditions. The Complementary List presents essential medicines for priority diseases for which special diagnostic or monitoring facilities, specialist medical care, and/or specialized training is necessary for their administration. The priority conditions in Saint Vincent include infectious disease like HIV, chronic NCDs like hypertension and diabetes, as well family planning services. The use of an EML can make procurement more effective because prescriptions will be more predictable and encourages physicians to prescribe the same medications, which increases order size which can lead to savings by unit price. It also serves as a guideline for physicians on medicines that will be easily accessible and are likely to be in stock. There are 291 drugs on the Saint Vincent EML. The EML is largely based on the WHO Model List of Essential Medicines.

There does not appear to be a body in place or the capacity at the MOHE to monitor compliance with the EML. Centralized public procurement from the EML will encourage providers to prescribe from this list. There are no legislative requirements for promoting use of generics (Abbott and Banneberg 2009); however, assessment interviews indicated that generic substitution is commonly practiced both in the public and private sectors. Draft regulations include a substitution policy. The EML contains mostly generics to promote cost-effectiveness in procurement for the public sector.

For most conditions, Standard Treatment Guidelines (STGs) do not exist. There are partial national treatment guidelines for HIV (Abbott and Banneberg 2009). The Pharmacy and Therapeutic Committee is developing guidelines for antimicrobials and has plans to create treatment guidelines for chronic diseases in the near future. The committee sees diabetes as a top priority as a study conducted in 2005

showed poor adherence to diabetes regimes in Saint Vincent. During the HSA interviews, PLHIV reported pharmacists dispensing improper medications for their condition and interviews with pharmacists confirmed that not all pharmacists dispensing ARVs have had appropriate training.

In the public sector, district pharmacists are often overwhelmed with patients and unable to spend the full amount of time they would like to with a patient when counseling them. Furthermore, many of the clinics do not have private space for counseling. A few years ago, MCMH added an enclosure that pharmacists there have cited as increasing confidentiality for PLHIV and, they reported, resulting in better adherence since patients stay for the full amount of counseling.

7.4 AVAILABILITY AND ACCESS

Household survey data on the availability and affordability of medicines are not available. However, during the assessment nearly all interviewees in district facilities noted stock-outs as a challenge. Stock-outs at the district level are of particular concern since private pharmacies are concentrated in Kingstown and therefore less able to fill in the public sectors gaps. Commonly out-of-stock items include IV fluid, hypertensives, aspirin, and consumables. Interviewees also reported stock outs of ARVs, particularly combination drugs. At the MCMH, stock-outs were not as common. Reasons for the stock-outs appear to be a combination of (1) cash flow shortages through the PPS to pay distributors in a timely fashion resulting in withholding of deliveries, (2) weak inventory management in district pharmacies, and (3) wastage of medications at MCMH. The MOHE has asked the Chief Pharmacist to investigate the issue further.

Currently, a user fee stamp of EC\$5 (US\$1.87) is required to fill prescriptions in the public sector. Patients buy the stamp at the local post office and must present it to the pharmacist in order to receive their medications. In recent years, local post offices have closed in rural areas, making it more difficult to buy the requisite stamp nearby. The health districts have reacted in various ways to this. Based on assessment interviews, some district pharmacists have allowed patients without stamps to access medicines free of charge while others have turned patients away. Likewise, during interviews some nursing staff reported concerns about access to medicines in districts where the pharmacists are strictly adhering to the stamp rule. As discussed in Section 3.3, Government Structures in Chapter 3, many groups including the poor are exempted from user fees. According to interviews conducted for this assessment, the user fees for prescriptions are not broadly enforced in the districts and nurses commonly inform pharmacists that patients cannot afford medicines. No one is denied access to medicines if they cannot afford it.

In the private sector, pharmacies also offer various price points to help meet the needs of clients. Private pharmacies commonly offer discount programs for frequent shoppers and seniors. Most retailer pharmacists reported working with their clients to offer lower prices because it is often the personal relationships between the pharmacist and the client that bring them into the pharmacy.

The MOHE has been exploring a program to offer a discount program for diabetic medications. The program in its current formation is designed to be similar to the one running in Saint Lucia, where the distributors can purchase medications for diabetes through the CMS. This program would allow distributors to get the medications at the same price as the PPS. The mark-up on these medications would be capped to guarantee lower prices in the private sector. The private sector has been receptive to this idea, but many retail pharmacies would like the policy to allow retailers to purchase from PPS so they do not have to pay the mark-up from the wholesalers. The discussion on this issue between the MOHE and private sector pharmacies and distributors has recently ebbed; if implemented, it would offer more affordable medications to many Vincentians.

7.5 FINANCING

Pharmaceuticals in the public sector are financed out of the government of Saint Vincent's Consolidated Fund. The revenue from the user fee stamps of EC\$5 is returned to the Consolidated Fund. The revenue, however, does not make a substantial contribution to the cost of medications as the user fees are minimal and not uniformly collected. Financing pharmaceuticals was a concern for many interviewees due the frequency of stock-outs. During the assessment, they suggested that they believed the issue of stock-outs was largely the result of insufficient cash flow by the MOHE at payment time that has forced the MOHE to prioritize which bills to pay.

Actual government expenditures on pharmaceutical supplies were EC\$6 million in 2009, the latest data available from expenditure and revenue estimates (GOSVG 2011a). For 2011, the MOHE estimated the pharmaceutical budget at EC\$6.5 million (GOSVG 2011a). Table 7.1 below shows expenditure data from the WHO World Medicines Situation Report from 2004. These data are likely to underrepresent true expenditure because no household expenditure survey or other regular mechanisms for reporting expenditures incurred has been conducted, and thus strong data are not available. The only available estimates are for private sector spending on pharmaceuticals, and also for pharmaceutical spending in the HIV response in 2004, as an HIV subaccount was conducted in 2006. This NHA HIV subaccount reports that 31 percent of OOP expenditures on health were for pharmaceuticals (UNAIDS and Abt Associates 2006). For more discussion on OOP and financing indicators for Saint Vincent, please refer to Chapter 4, Health Financing.

TABLE 7.1: PHARMACEUTICAL EXPENDITURE INDICATORS FOR SAINT VINCENT, 2000

	Saint Vincent	Year of Data	LAC
Total expenditure on pharmaceuticals (% total expenditure on health)	23.7	2000	23.2
Total expenditure on pharmaceuticals (per capita at average exchange rate) in US\$	40.00	2000	41.79
Government expenditure on pharmaceuticals (per capita at average exchange rate) in US\$	23.00	2000	12.21
Private expenditure on pharmaceuticals (per capita at average exchange rate) in US\$	18.00	2000	32.45

Source: WHO (2004)

PAHO's 2007 Health in the Americas publication reported that in 2004 medications in Saint Vincent for diabetes cost US\$407,154 and medications for hypertension cost US\$230,032. The two combined represented 20 percent of the annual pharmaceutical budget in the Saint Vincent public health system. Prices for medicines are generally affordable in the public sector as they are heavily subsidized and even provided free of charge when necessary. Additionally, contraception and routine childhood immunization are provided free of charge in the public sector. ARVs are available free of charge in Saint Vincent, thanks largely to contributions from external donors. The OECS Round 10 proposal to the Global Fund was not approved and funding from previous rounds expired in early 2011. The new grant would have supported preferred provider services for vulnerable populations, particularly for treatment. The Round 9 grant from the Global Fund awarded to PANCAP will fund first-line and second-line ARVs for two years starting in 2011, with an increasing government contribution each year. Brazil has an agreement with the PPS to provide free first-line ARVs through 2013 with shipment costs picked up by UNICEF. In September 2011, the OECS/PPS received for the benefit of its members a donation of ARVs valued at EC\$272,000 from Trinity Global Support Foundation based in Canada (OECS 2011b). The donation was initiated by the Rotary Club of Gros Islet, Saint Lucia, which provided an additional EC\$6,000 grant to distribute the ARVs to the other OECS countries.

Prices in private pharmacies generally offer affordable prices for most Vincentians and the consumers keep the prices low through comparison shopping. Price controls exist for private sector mark-up. Wholesalers are allowed a 12 percent mark-up and retailers are able to levy an additional 13 percent mark-up on the cost they pay. Based on CARICOM policies, certain essential medicines are value added tax (VAT) exempt, while medical products are not.

7.6 RECOMMENDATIONS

7.6.1 SHORT-TERM RECOMMENDATIONS

Develop Standard Treatment Guidelines to promote standardized, quality care and more cost-effective treatments

STGs list the preferred treatment for common health conditions. These guidelines promote standardized, quality care and can promote more cost-effective treatments. STGs offer patients consistent and effective treatment and allow supply managers to better predict demand for certain medicines. Currently very few STGs exist in Saint Vincent, but the Pharmacy and Therapeutic Committee is in place and capable of creating these guides. The Dental and Medical Association, along with civil society groups like the Diabetes Association, could assist the committee with developing these guidelines. These guidelines could better direct appropriate prescription practices that line up with the availability of drugs on the EML. Other OECS countries have developed STGs that could be used as a foundation to quickly move this recommendation into action.

Train pharmacists in antiretroviral drug dispensing to ensure people living with HIV are adhering appropriately to their regimen

Training in ARV dispensing is needed to ensure that PLHIV are adhering appropriately to their regimen. All pharmacists dispensing ARVs should receive training. A request for training from I-TECH could easily be implemented in upcoming work plans for technical assistance.

Hire more pharmacy students to assist district pharmacists with inventory management to avoid stock-outs at health clinics and district hospitals

In MCMH, the pharmacy uses students to assist them with various tasks including inventory. This system seems to alleviate some of the workload on pharmacists. This system might help district-level pharmacies overcome current human resource constraints as well, and the utility and feasibility of implementing this system should be explored further. Hiring more students or pharmacy technicians could improve the inventory management in the district pharmacies at a cost that is lower than hiring more trained pharmacists. To qualify as pharmacy technicians, training for pharmacy technicians may be necessary but would be more cost-effective than training more pharmacists overseas. For example in Saint Lucia, pharmacy technicians often get online certificates from Penn Foster Career School, where the cost is approximately US\$450–\$600 (depending on the availability of promotional deals), compared to a place like UWI where tuition is listed at approximately US\$12,600 per academic year.

Request immediate fast-tracking of the review for the Pharmacy Act Regulations and assist in finding ways to address personnel issues in the Attorney General's office to complete the reviews

The regulations for the Pharmacy Act have not been passed yet. These regulations are very thorough and the Pharmacy Association and Pharmacy Council have spent a great deal of time researching other countries' regulations and adapting them to the Vincentian context. But without these regulations, the Drug Inspector has little ability to enforce what is believed to be appropriate or inappropriate. Furthermore, without these regulations, the Pharmacy Act has limited regulatory authority. Some pharmacists and pharmacy owners perceive the enforcement to be based on political party affiliation or

personal interests rather than on sound logic and law. It is vital that these regulations are approved as soon as possible for proper regulation of the sector, especially at a time when the private pharmacy industry seems to be growing. The MOHE should request immediate fast-tracking and assist in finding ways to address personnel issues in the Attorney General's office to make this happen.

Initiate dialogue between the Pharmacy Association and mental health professionals to reach a compromise on dispensing of medications at mental health clinics by nonpharmacists

The Pharmacy Council, Pharmacy Association, and mental health professionals need to engage in a dialogue in order to understand the concerns of all parties with regard to dispensing medicines at community mental health clinics. A plan should be formulated to ensure mental health patients are able to access the care they need in the community clinics because it is highly unlikely that these patients will travel to Kingstown to fill a prescription. Until regulations are passed, a stopgap solution must be devised. The MOHE should initiate this dialogue but allow the two sides to find an approach that will work for both.

7.6.2 LONGER-TERM RECOMMENDATIONS

Increase budgetary control for the Central Medical Stores and labs

The labs and the CMS need greater control over their budgets so they can prevent or respond quickly to stock-outs. A long-term solution would likely require the passage of some type of autonomy act. Before pursuing this course, however, stakeholders should carefully consider the financial management capacity at the labs and the CMS, as a delegation from the Budget Authority may require training before implementation. Building this capacity may be something that the PPS could help with.

Collaborate with private sector to supplement the Essential Medicines List with brand-name medications that the private sector, unlike the public sector, may be able and willing to sell

The creation of the EML is an excellent start to making drug procurements more cost-efficient, as long as doctors adhere to the list. The generics policy in the draft regulations for the Pharmacy Act will also promote cost savings. If the public sector is moving to providing mostly generics, the private sector will become the main providers of branded medicines. In this way, the private sector could complement what the public sector offers and not compete directly. Further conversations between the public and private sectors could be useful in identifying medicines that the private sector can and is willing to provide, thus relieving some of the burden from the public sector. This dialogue could also facilitate negotiations of a policy on discounted medications for CNCDs currently being explored. Saint Lucia may be a good model to use for both of these policies because it currently has these types of policies and shares the same regional challenges.

Advocate for a clinical pharmacist position

A clinical pharmacist could provide MCMH with someone who could advise doctors on the medications available from the pharmacies, help manage treatment on the wards, and monitor what is being done with the medications to prevent wastage. Implementing this plan would require a budget allocation which does not seem available currently. The MOHE should begin advocating for introducing the position of clinical pharmacist as a cost-saving effort when the funds from the MOF do become available.

8. HEALTH INFORMATION SYSTEMS

Key Findings

- Portions of the electronic SVGHIS system have been rolled out to 70 percent of the public health facilities
- Good technical infrastructure (i.e., networks, computers, secure buildings) is in place across health facilities to support SVGHIS
- HPIU is understaffed to support the needs of a nationally implemented SVGHIS in the long term
- Absence of single patient identifier nationally (across all programs, not just health) limits the capacity of SVGHIS to uniquely track patients
- Data quality is not currently tracked
- A feedback loop for HPIU to share and discuss data with primary health facilities is not consistently practiced

An HIS is defined as a “set of components and procedures organized with the objective of generating information that will improve health care management decisions at all levels of the health system” (Lippeveld et al. 2000). The HIS typically serves four functions: (1) data generation, (2) data compilation, (3) data analysis and synthesis, and (4) data communication and use (Health Metrics Network 2008). The HIS collects data from the health sector and other relevant sectors; seeks to analyze the data and ensure their overall quality, relevance, and timeliness; and converts the data into information for health-related decision-making. The functioning of the HIS at the national level provides a strong indicator of the overall health system’s functioning. The following section provides an overview of the key structures, findings, and recommendations relevant to the Saint Vincent HIS.

8.1 OVERVIEW

The HIS in Saint Vincent today is in transition from a paper-based data capture and reporting, to a web-based electronic HMIS (known as the SVGHIS) with patient record-level data capture accessible across all public health facilities in the country. This transition has the potential to drastically improve the availability of clinical and epidemiological information, but also has the potential to overwhelm the limited HPIU staff managing the software customization, personnel training, system implementation, and technical support for the SVGHIS. The HPIU also has limited central staffing capacity to aggregate, analyze, and disseminate timely health information for effective decision-making. It has taken more than six years to customize the open-source HMIS, prepare the infrastructure to support the computer-based system, allocate the financial resources to hire technical support staff, and initiate implementation. Though the target for full implementation of the SVGHIS was originally set for the end of 2008, delays have pushed the target for implementation of initial modules at all facilities to the first quarter of 2012. These delays highlight the challenges that the HPIU will continue to face in moving from implementation to full usage of the SVGHIS.

8.2 HEALTH INFORMATION SYSTEMS SUPPORT TEAM STRUCTURE AND RESPONSIBILITIES

The primary unit within the Saint Vincent MOHE responsible for HIS as defined above is the HPIU, which is overseen by the National Epidemiologist. The HIS support team is led by a Systems Analyst, who reports directly to the National Epidemiologist. Within the HPIU, the staff members are split between Surveillance and Information Management Support. According to the National Epidemiologist, four full-time permanent staff positions are budgeted for Surveillance: a Senior Statistician, a Junior Statistician, a Data Clerk, and the National Epidemiologist. Instead, in addition to the Epidemiologist, three junior staff members are employed to capture surveillance data and vital statistics: one collating statistics, one conducting data entry, and one acting as the medical librarian. The Medical Librarian has initiated outreach to the Mental Health Rehabilitation Center and to the Lewis Punnett Geriatrics Center, which do not routinely report data to the HPIU.

The Information Management team includes one Coordinator, one Systems Administrator, and one Programmer/Analyst. The Coordinator is a senior staff member who has been on education leave for the last year to obtain a Master of Science degree in Health Informatics. The Coordinator has one year to go before finishing the program and potentially returning to the HPIU. The Information Management team is primarily focused on planning and supporting information and communications technology (ICT) across the MOHE. The HPIU is also supported by contracted employees in the roles of Developers (two employees), System Analyst (one employee), Development/Training/Specifications Specialist (one employee), and Customer Support (four employees). The HPIU is responsible for implementing the SVGHIS, which is being rolled out across the country in phases. One staff member from the HPIU also sits on the national-level ICT Technical Working Group, which is responsible for coordinating information systems strategies across Saint Vincent's ministries and departments. In addition, the HPIU has access to the services of a contracted consultant from the Canadian developer of the SVGHIS who will reside locally for another year. Overall, the technical capacity of the HPIU team is very strong, but the gap between budgeted positions and officially filled positions continues to create constraints.

8.3 EXISTING PLATFORMS AND RECORD KEEPING

Data reporting on routine health statistics is conducted at the health clinics on paper, with forms sent to the district hospital and then onward to the MOHE. All data is aggregated at the central level, where it is compiled into Excel databases. The Health Digest of Basic Health Indicators, 2005–2009, is the latest compilation of epidemiological data for Saint Vincent. The report contains extensive tabular and graphical data on health statistics for the five-year period covered, but does not provide any contextual analysis to explain the data (MOHE 2011a). Based on site visits to several of the health clinics and district hospitals, the usage of information collected is quite good. The staff at the health clinics compile and post their monthly statistics on a designated wall of the facility in hand-written tables. The tables track their targets and progress toward their targets. While not electronically tabulated and produced, this type of system indicates a strong understanding of the value of using data. See picture of a sample chart in Figure 8.1.

FIGURE 8.1: CLIFTON HEALTH CLINIC DATA WALL, UNION ISLAND



Source: Site visit, Assessment Team (2011)

Saint Vincent received US\$7 million from the World Bank between 2005 and 2011 to support the development of its HIV prevention and treatment programs. A key component of this program was targeted toward building the infrastructure to conduct effective HIV/AIDS M&E. Saint Vincent leveraged those funds to identify and acquire an electronic health record (EHR)-based HMIS. In the early vision for the electronic HMIS, the health facilities would capture patient information (from demographics to clinical diagnoses to treatment plans) in the EHR, which would then allow for aggregated electronic reporting to the MOHE. The system has become known as the SVGHIS and is built on an EHR platform known as ACSIS from the Canadian company Accesstec, Inc. Based on interviews with the HPIU Senior Analyst, the SVGHIS system contains the following seven modules:

- HIV/AIDS
- Supply Chain Management
- Human Resources
- Electronic Health Records
- Admission & Discharge (Inpatient)
- Maternal Child Health
- Clinician Order Entry

Three additional modules, Finance, Laboratory, and Public Health, will be incorporated into the functionality of the system by the HPIU programmers. Two HPIU staff have received training in coding and customizing the SVGHIS system; support is also provided by the Accesstec consultant who, as mentioned above, will be available locally for another year via contract.

A key functional benefit of the SVGHIS for Saint Vincent is that it is a web-based system with a consolidated open-source database installed on a central server. This architecture minimizes the technical infrastructure requirements at each installation site, simplifies technical support, and streamlines the updating process. All that is needed for access at any location is a computer, a secure internet connection routed to the database server, and the appropriate user access rights. Also, SVGHIS will create a local replication of the database, allowing the users to work offline when access to the central server is not available (e.g., the internet connection between a health clinic and the server is not working) and then to automatically synchronize the records databases when there is connectivity.

Based on the work plan and project plan, the SVGHIS was initially expected to be fully implemented and operational by the end of 2008. Significant challenges in software customization, in ensuring that health facilities were outfitted with the appropriate security to protect new equipment, and in limited staffing have all contributed to delays in the roll-out of the SVGHIS. During interviews and site visits for this assessment, the system was shown to be working well. All staff interviewed at clinics during the assessment indicated that they had received training in how to use the SVGHIS, although for some there was a significant lag between their initial training and the timing of the system implementation at their facility.

A primary concern observed by the assessment team was that no specific plan had been developed for capturing historical patient information in Saint Vincent's electronic health records. While the SVGHIS will allow providers and health administrators to view patients' basic demographic information (populated through data transfers from other Saint Vincent information systems), the electronic patient records will by no means contain the full patient medical history. The paper medical records that exist for most patients will not be backfilled into the system, thus requiring the use of both paper and electronic records for information capture. In addition, the reporting component of the SVGHIS has not yet been customized and implemented, requiring that current reporting to MOHE continue on paper forms. The SVGHIS will assign each new record (and therefore patient) with a unique identifier. This identifier, however, is not part of a national identifier that would uniquely identify a Vincentian across all public information systems, such as those for vital registration, voting and/or education. The introduction of a national unique identifier would improve the tracking of patient information within the SVGHIS as well.

Interviews with Medical Records staff at MCMH, the largest health facility in terms of patient visit volume in the country, indicate that they are transitioning patient registration information into the SVGHIS as new patients check in. The Medical Records staff now look up registration numbers for patients who have visited the hospital before in a master spreadsheet that they maintain in Microsoft Excel. The data in the Excel tables is based on the paper registry maintained by the Medical Records Department for any new patient presenting at the hospital. A review of the registry during the assessment site visit indicated more than 168,000 patient records have been logged into their registry and paper medical record files created. These paper medical records are stored in an overcrowded space, which the Medical Records staff indicate becomes more difficult to manage each year. Despite this issue, a simple sampling of the medical records at the time of the site visit showed that most records could be retrieved with relative ease based on the numerical filing system maintained.

8.4 INDICATORS

The Strategic Plan for Health presented a set of strategic indicators for monitoring improvements in the health system. It did not, however, define a minimum set of health indicators for priority diseases, for example, that are part of the national routine reporting system. One of the anticipated outcomes of the forthcoming EU-supported Nutrition and Disease Burden Survey is the development of baseline indicators for tracking progress against NCD prevention and treatment. For the HIV/AIDS program, numerous targets and indicators have been developed and tracked based on program reporting

requirements to the Global Fund and the World Bank. While initially an overwhelming task to manage and consistently report, interviews with key stakeholders noted that the number of HIV/AIDS indicators regularly reported had been reduced to 35 in total. NAS, which has been incorporated into the MOHE structure, manages this process.

8.4.1 VITAL STATISTICS IN REPORTING

Statistical information on births, deaths, marriages, and divorces are collected from the Department of the Registry. In Saint Vincent, the majority of the births annually (more than 99 percent) take place in a hospital, particularly MCMH which accounts for 92 percent, and these hospitals become the location where primary information on births is initially captured (European Commission Development and Cooperation 2008). Family members are required to register births (and deaths) with the district registrar, which then reports them to the Department of the Registry. Every parent in Saint Vincent has three months from the date of birth of the child within which to register the birth of a child. Deaths are reported in a similar fashion and should be coded according to the International Classification of Diseases, Version 10 (ICD-10). This coding is done in the HPIU by the National Epidemiologist, where there is a significant backlog of records for coding due to insufficient coders with appropriate training and certification.

There is currently no centrally located and commonly agreed-upon database with primary data for each citizen in Saint Vincent that could be utilized to assign a unique patient identifier. There are various databases owned by such entities as the NIS, the Department of Registry, the MOHE, and the Electoral Commission. The absence of process to assign a unique national identifier poses a challenge to the ability of the SVGHIS to maintain a distinct record for each patient over time, especially between public and private health care points of care. Ensuring quality of care issues, such as reviewing drug-drug interactions, is more challenging when there are possible duplications of health records in the system.

8.4.2 SURVEYS AND THE CENSUS

The Statistics Office is located within the Central Planning Division of the MOF and is headed by a Chief Statistician. The duties of the Statistics Office, as stated in the Census and Statistics Act of 1983, are to:

- Collect, compile, analyze, abstract, and publish statistical information relative to the agricultural, commercial, industrial, financial, social, and general activities and conditions of the inhabitants of Saint Vincent
- Collaborate with the departments of the government in the collection, compilation, and publication of statistical records of administration
- Take any census of Saint Vincent and the Grenadines as provided in this act
- Generally organize a scheme of coordinated social and economic statistics pertaining to Saint Vincent (GOSVG 1983)

There are three units within the Statistics Office: Social, Economic, and Trade. The Social Unit is responsible for the collection, compilation, and dissemination of vital statistics (i.e., births, deaths, marriages) and for preparing annual population estimates and projections. The Social Unit is also responsible for supporting all health-related surveys, including tracking Saint Vincent's progress towards achieving the Millennium Development Goals and the decennial census. The last full census completed and published for Saint Vincent was done in 2001; the results and data tables from that census are

publicly available through the Statistics Office's website.⁴ The 2011 Vincentian census was officially launched by the Prime Minister at a rally in February 2011. In order to build excitement and encourage citizen participation in the census, the Statistics Office launched a publicity campaign, which included sponsoring a study essay contest, organizing a census log competition, and establishing a Facebook page for the census (GOSVG 2011b). The census counts were taken in June 2011 and at the time of the on-site interviews by the assessment team in August 2011, the census data were being analyzed with the expectation of sharing final data publicly in the early part of 2012. Recent news reports, however, indicate that a major fire at the Financial Complex in Kingstown destroyed data that was being reviewed there and that Saint Vincent "may be forced to redo the 2011 Population and Housing Census" (Caribbean 360 2011).

The Statistics Office works with the HPIU and Department of Registry on compiling vital statistics. Reports come from the Registrar's Office to the Statistics Office on a quarterly basis. The Statistics Office does not employ any staff with geographical information systems (GIS) technical expertise to support the development of health maps, nor does it have direct access to other staff with these skills within the Corporate Planning Unit of the MOF, according to interviews with staff there.

8.5 REPORTING RESOURCES

8.5.1 FINANCES

The HPIU has a dedicated section in the national health budget of Saint Vincent. Based on a review of 2010/11 budget figures, the HPIU was able to add two funded positions, one in the role of the HIS Coordinator and one in the role of Systems Administrator (MOHE 2011b). Based on interviews across the MOHE, staffing increases within MOHE's management and administrative units are largely dependent upon overall budget increases for health rather than on specific line-item requests. Overall, the HPIU accounted for 40 percent of the personnel budget for the central administration of the MOHE (MOHE 2011b).

8.5.2 POLICIES AND REGULATIONS

The primary policy in place in Saint Vincent relevant to HIS is the Census and Statistics Act, which statutorily defines the role of the Statistics Office. The act notes that "the census shall be taken" but does not specify specific intervals, merely stating that it should take place "on such day in any year as the Minister may fix" (GOSVG 1983).⁵ Timeliness and breadth of dissemination of this information is not addressed under the act. In principle, all information collected from the public health sector in Saint Vincent is available to those who request the information. The FOIA was approved by the Saint Vincent Assembly in 2003, but has not yet been signed into law. (For more information, please see Section 3.2.1, Civil Society Environment, in Chapter 3, Governance.) The continuing roll-out of the electronic SVGHIS highlights an additional area that has not yet been addressed in Saint Vincent: data privacy and security. As more information in Saint Vincent becomes digitized in electronic health records, it will become increasingly important to explicitly recognize that information as legal documentation and as being formally protected private information under Saint Vincent law.

⁴ statisticaloffice.digitalsvr.com

⁵ The act does not specify which minister has the authority, but does imply the Minister of Finance, as the Statistics Office is housed in the MOF.

8.5.3 TECHNICAL INFRASTRUCTURE

As noted earlier, there is a relatively strong and stable infrastructure to support the SVGHIS currently being rolled out. There is also a modest amount of telemedicine – or the use of electronic tools to remotely provide health services – taking place. The WPP, an international NGO active in Saint Vincent, collaborates with the University of Richmond Children’s Hospital and MCMH to support a limited amount of distance education for the pediatric support staff at the hospital. In addition, according to interviews and documents reviewed for the assessment, one private sector imaging center in Kingstown routinely sends diagnostic images to an off-island resource for interpretation. This process is routinely done for patients seeking tertiary care services in other parts of the Caribbean.

8.6 DATA COLLECTION

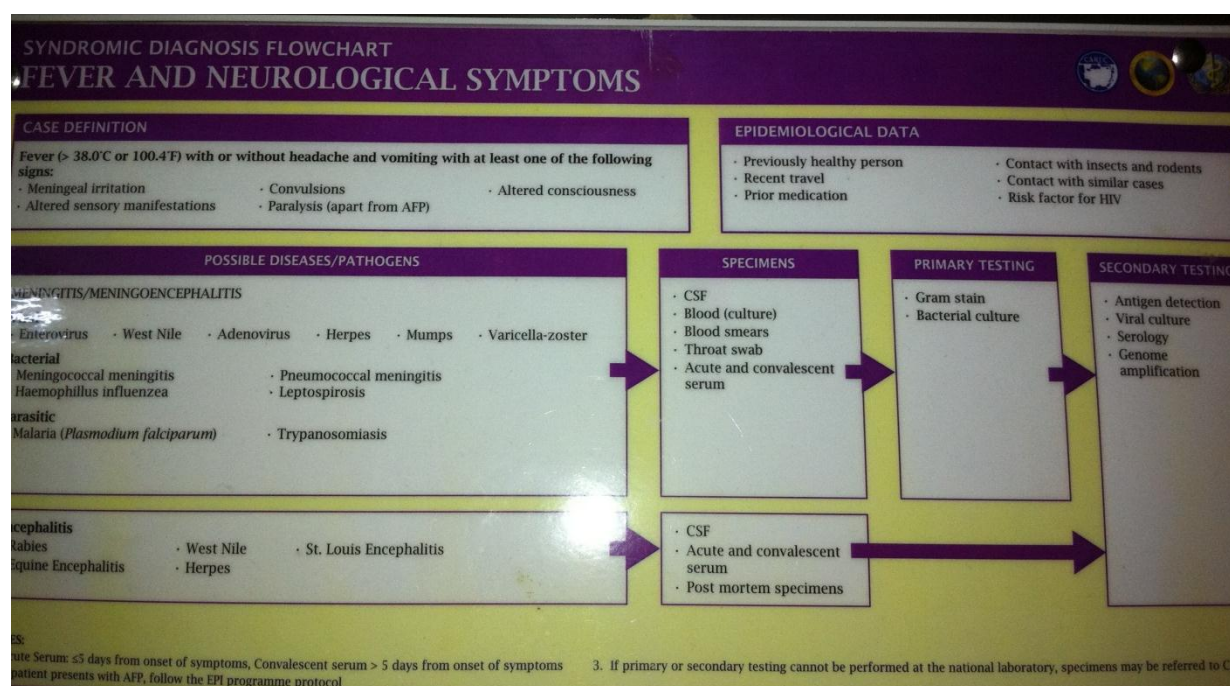
8.6.1 AVAILABILITY

There is widespread concurrence among the stakeholders interviewed for this assessment that health data are available and team members observed at multiple primary care facilities that information is being utilized locally for tracking and planning purposes. A primary challenge in Saint Vincent with the health data reported from the health facilities is aggregating it, analyzing it, and disseminating it in a timely manner. The limited staffing within the MOHE to perform these aggregation and analysis duties was a commonly cited reason during key stakeholder interviews for the delays in compilation and the limited distribution of compiled data. Interviewees across a number of offices during the assessment in Saint Vincent also noted that there was typically little demand for data and no sanctions of any sort when health statistical reports were not completed.

8.6.2 DATA FLOW AND CONSOLIDATED REPORTING

Syndromic surveillance data is reported to the MOHE on a weekly basis by a staff member from health facilities by telephone or fax. A multisectoral Surveillance Committee, headed by the National Epidemiologist, meets to review the data compiled and approves the distribution of a weekly syndromic report. Interviews with the Health Planning team indicate that limited staffing resources make surveillance follow-ups quite difficult, particularly during outbreaks for diseases like dengue. There was strong interest among interviewees in exploring electronic reporting of syndromic cases to minimize the time costs.

FIGURE 8.2: SYNDROMIC DIAGNOSIS FLOWCHART FROM DISTRICT HOSPITAL



Source: 2011 Site Visit, Assessment Team (2011)

At the primary health care level (clinics and district hospitals), routine health statistics are compiled by a registered nurse who reports the data to the District Supervisor (i.e., the District Nurse) on a monthly basis. After reviewing the data, the District Nurse forwards the district data from all facilities to the Senior Nursing Officer in Kingstown. The Senior Nursing Officer then reviews and forwards the data from all nine districts to the HPIU. A major priority noted under the Saint Vincent National ICT Strategy is to “complete the health information backbone as part of the government backbone” which would serve as the pathway through which electronic data from the SVGHIS can flow (GOSVG 2010b). According to interviews and documents reviewed during the assessment, Saint Vincent is well on its way to achieving the connectivity objectives of having more than 95 percent of public health facilities equipped with complete electronic network installation tied into the government backbone (MOHE 2011c).

8.6.3 QUALITY

There are no formal procedures in place to evaluate and improve data quality across the Saint Vincent health system. There are, however, several informal processes that take place to review data submitted through the various reporting streams to the central level. At this time, neither the Nursing Office nor the HPIU tracks statistics on how many of the nine districts reports on-time and for each month. Based on interviews during the assessment, there are no written, formal guidelines addressing data quality, such as timeliness, accuracy, and completeness.

8.6.4 PRIVATE HEALTH SECTOR REPORTING

There are no legislative requirements for health care providers in the private sector in Saint Vincent to report health data to the government. Saint Vincent does not have, for example, a Notifiable Conditions Act (or similarly named) in place. A Notifiable Conditions Act typically details which communicable diseases are required to be reported, within what timeframe, and to whom. Based on interviews with

staff in both the public and private sectors, the reporting of high-risk communicable diseases, such as dengue or cholera, is done on a voluntary basis in Saint Vincent, but not in a systematic or comprehensive way.

8.7 DATA ANALYSIS

The HPIU and Epidemiology Unit both suffer from very limited staffing. The primary areas where shortages of staff exist are in the domains of M&E and data analysis. There appears to be fairly good capacity in place to capture and report data from the facility level to the central level. However, the capacity to analyze this data and compile comprehensive reports with the results is very limited. As noted above, the officially approved staffing levels within the HPIU for more senior-level staff positions have not been put into place and cause staff to be significantly overstretched in their assignments.

There are very limited local opportunities in Saint Vincent for training in data analysis, M&E, and HIS. The staff of the Caribbean Health Research Council, based in Trinidad and Tobago, made a recent trip to Kingstown to provide training in M&E within HIV/AIDS programs for the MOHE staff, but this was noted to be a one-off training as opposed to being part of a regular cycle of M&E training. Many staff noted during interviews that the absence of local training capacity in these domains is a key barrier to improving the culture of information and demand for data in Saint Vincent.

8.8 USE OF INFORMATION FOR DECISION-MAKING

8.8.1 POLICIES AND GOVERNANCE

The OECS has been supporting Saint Vincent under a World Bank-funded initiative to implement E-GRIP. The loan awarded US\$2.4 million to each OECS country, which can only be accessed through the OECS as directed by the E-GRIP team. E-GRIP primarily focuses on common frameworks for integrating commerce across the OECS countries, such as uniform customs clearance processes. Health components are also specifically called out in the E-GRIP project documents.

This subcomponent [E-Government in Health and Other Social and Productive Sectors – (US\$830,000)] will provide assistance in the implementation of a **regional pilot project in health management information systems**... The core health elements of this subcomponent will explore options, in synergy with existing efforts, for implementation of standardized hospital facilities management systems and electronic patient records, including key linkages with national identification systems and civil registries, as well as regional epidemiological monitoring programs.

The subcomponent includes the following activities: (a) Implementation of a regional e-government pilot project in the health sector through, in particular, the design and implementation of a regional health management information system, which may include facilities management systems, electronic patient records, regional information network and on-line tools for Health Ministries; (b) Preparatory activities and/or complementary support to existing e-government initiatives in other social and productive sectors, notably agriculture and tourism, as well as education, postal sector, or others as may be identified in the early stages of the project. (OECS E-GRIP 2008)

As noted here, the focus for E-GRIP within health has been on creating a regional HMIS. Toward that end, E-GRIP has engaged external consultants to facilitate both an assessment of the national HIS (for

the OECS countries, including Antigua and Barbuda, Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia, and Saint Vincent and the Grenadines) using the Health Metrics Network framework and tools, and the application of the Performance of Routine Information Systems and Management (PRISM) framework and tools, which focuses specifically on determining the organizational, behavioral, and technical determinants of the routine HIS performance. To implement both assessments, the external consultants have trained OECS country teams on the frameworks, methodologies, and tools; these teams are then expected to lead the assessments in their respective countries. Based on discussions with the HIS stakeholders in Saint Vincent, the overall objectives of the E-GRIP initiative and the benefits to each individual country have not been clearly articulated to them. The E-GRIP-sponsored assessment reports have been provided to the Health Information team at the MOHE, but next steps are not clear to the assessment team.

8.8.2 PLANNING AND BUDGETING

There is widespread documentation that highlights the need to address NCDs as a growing health concern in Saint Vincent. From the internal Strategic Plan for Health to external PAHO assessments, extensive documentation of the challenges posed by NCDs to the Vincentian population has taken place. While the need (i.e., the demand) has been addressed, there is little evidence that budgeting for health priorities (i.e., the supply) has been impacted by data from programs. Interviews with key stakeholders in the MOHE indicate a strong desire to improve the use of data for informed decision-making, which is a key driver for implementing the electronic SVGHIS.

8.9 RECOMMENDATIONS

The following summarizes the key recommendations in the HIS module.

8.9.1 SHORT-TERM RECOMMENDATIONS

Leverage the E-Government Regional Integration Project work plans and team to move the dialogue on national identifiers forward

Stakeholders from the countries participating in E-GRIP all face similar challenges and constraints, including those concerning national identifiers. The current E-GRIP team is actively engaged in solving regional issues and collaboration can help regional stakeholders move the discussion forward in a common manner.

Pool technical resources with neighboring island (Saint Lucia) staff to share best practices and lessons learned on SVGHIS (based on utilization of the same platform)

Saint Vincent has acquired and is implementing the same software system (ACSiS) as Saint Lucia for its electronic HMIS backbone. Both Saint Vincent and Saint Lucia have very limited staff for development, training, implementation, and technical support. Leveraging human/technical resources across the two islands would potentially reduce their individual burdens and allow them to share best practices, as well as lessons learned.

Leverage the SVGHIS to engage the private health sector

Minimal data on routine health services is provided to the MOHE by the private sector. The cost of acquiring the SVGHIS has already been paid, so no ongoing licensing costs are required. The MOHE could potentially offer the SVGHIS for free (in terms of purchase price) to the private sector as a means of incentivizing them to report data to the MOHE. Though increasing and regularizing data flows from the private sector would make the SVGHIS more powerful/valuable, it will also require significantly more technical support staff to support the additional system users. The MOHE should also initiate

dialogue to ascertain the private sector's interest in such an arrangement, while also identifying their interests in having more data shared with them.

Explore opportunities to pilot and test telemedicine programs within the Grenadines before initiating robust links with external partners

There are severe shortages of some clinical specialty areas in Saint Vincent, due in part to the absence of a sufficient patient base to support a full-time, on-island provider. Psychiatry provides a clear example of this type of need. Telemedicine presents an opportunity to initiate a public-private dialogue around common areas of interest, with an emphasis on meeting service delivery needs for the Saint Vincent health system. Telemedicine collaboration is also an area that could benefit multiple countries in the region, which also suffer from limited access to on-island specialty care.

Implement the Routine Data Quality Assessment Tool across the system

There are currently no formal data quality assessment processes in place with respect to data being reported to the MOHE. Mechanisms, such as the Routine Data Quality Assessment (RDQA), that incorporate both data review and feedback components in their process, are available. Implementing an RDQA mechanism in Saint Vincent will likely improve the quality of reported data, while also creating a feedback structure between the central and district levels and the district and facilities levels. The RDQA also has a complete set of user guidelines and training materials which would simplify its implementation in Saint Vincent.

8.9.2 LONGER-TERM RECOMMENDATIONS

Build upon the electronic reporting platform to explore electronic reporting of syndromic surveillance data

The current reporting of notifiable conditions and/or disease outbreaks is done via fax or telephone and data is recorded by hand. This has been cited as a time-consuming and labor-intensive undertaking by key HIS stakeholders in Saint Vincent. Given the increasing availability of the SVGHIS for routine data reporting, leveraging SVGHIS for surveillance reporting merits consideration as an option for Saint Vincent. A core team involved in the data capture and evaluation process should convene to explore the options for reporting directly to a centralized database via the SVGHIS.

Develop a formal staffing plan to support the SVGHIS long-term

The HPIU in the MOHE continues to be understaffed for its current activities. With the roll-out of the SVGHIS, the workload will only increase. It is recommended that the MOHE develop a formal HMIS staffing plan that ties to the projected activities, defines the specific roles and responsibilities of each position, and includes a recruitment and retention component. Where skills for the required positions do not exist, plans for the development of training programs to create a long-term cadre of workers should be explored.

9. PRIVATE SECTOR CONTRIBUTIONS TO HEALTH

- A diverse private medical sector serves an estimated 40 percent of Saint Vincent citizens. Limited data suggest that all socioeconomic classes access private sector health services
- The corporate sector has supported and informally partnered with the MOHE for a number of notable efforts in health education and wellness, support services, environmental health, and HIV prevention
- The WPP is a significant public-private partnership for Saint Vincent. The activity has the potential to mobilize significant resources to create a regional pediatric surgical wing to house foreign medical missions for regional surgery, with direct and indirect contributions from the MOHE
- Weak professional organization and lack of sufficient regulation and quality assurance undermine private medical practice. This includes a loosely regulated dual practice among physicians
- With no formal mechanism for engagement, the potential for fruitful collaboration between public and private health sectors is limited

9.1 INTRODUCTION AND OVERVIEW

The role of the private health sector is often not explicitly conceptualized in a health systems framework. Harnessing the private sector can relieve constraints in delivering essential health services. It can also result in increased efficiencies in management and resource utilization, a broader market for health promotion messages, and greater responsiveness to consumer preferences. The private health sector can increase the scope and scale of services available in Saint Vincent in important ways. For example, the private sector can potentially reduce overcrowding in public facilities, provide access to specialists, expand availability of diagnostic services, and fill gaps when public sector drugs and supplies are unavailable. Corporate, nonhealth entities also invest in health education and services, and government engagement with these entities may leverage additional resources that lead to increased access to health services with improved health impact for the country.

This section uses a private sector lens to identify ways to improve the availability, affordability, access, equity, and use of health services in Saint Vincent, maximizing the potential of the private sector. The objectives are to identify factors that can create an enabling environment for private sector participation in health to ensure more equitable access and sustainable quality health care for the citizens of Saint Vincent.

The private sector in Saint Vincent was broadly defined for the purposes of the assessment. The focus was on health service delivery organizations, although stakeholders who contribute health education and wellness activities through corporate and civil society (e.g., NGOs) programs were also interviewed. These additional stakeholders expand accessibility of health care through their investments, particularly for the benefit of their interest populations or employees. Their participation in Saint Vincent's health sector allows them to contribute to the cost of providing health, wellness, and educational services that are not borne by the government.

The private sector stakeholder domains identified for the assessment in Saint Vincent include:

- Nongovernment health services – private doctors, nurses, dentists, and therapists, operating in solo

practice or as part of a small clinic or subcontracted to a nursing home

- Diagnostic centers – radiology and laboratory pathologists and technicians
- Supply chain – pharmaceutical distributors and wholesalers, and pharmacists
- Private health financing – private health insurance, citizen OOP cost, and company-supplied health care and wellness services
- Private health care facilities – nursing homes
- Corporate social responsibility health programs – short-term corporate funding of health and wellness campaigns and corporate engagement in health policy

9.1.1 PRIVATE HEALTH SERVICE DELIVERY

Through a review of public information, such as the Yellow Pages, and stakeholder interviews, the assessment team identified the following as providing exclusively private health services:

- 25 physicians
- 13 pharmacies
- 4 labs
- 1 medical imaging center
- 5 nursing homes
- 15 dentists
- Nurses working for private sector services

In most health sector documents in Saint Vincent, the Maryfield Hospital is reported as being a privately-run 12-bed hospital with abilities to perform surgery. However, when the assessment team visited the hospital, it appeared locked and closed. After several phone calls to the owner, the assessment team was told that the hospital had closed because of the mounting costs required to run it. There were no other privately operating hospitals on the island at the time of the assessment.

Other private businesses provide commercial services that potentially influence public health on the island. Examples include:

- Environmental health/pest control services that are experienced in mosquito control
- Five private nursing homes, which keep doctors on retainer and employ private nurses
- Private health insurance companies that provide policies for some companies through employer policies
- Trinity Medical School, an offshore private medical school that provides some continuing education courses to the island's providers and offers lower fees for residents to attend medical school

During interviews with key stakeholders, there were a number of reasons cited as to why Saint Vincent patients seek care in the private sector. Convenience and confidentiality were the most-cited reasons during interviews for visiting providers in the private sector, according to private providers. Additionally, waiting time is usually shorter at private facilities and choice of provider is guaranteed for those who may seek a particular individual; quality of service was not cited as the principal reason for choosing private providers. The number of providers operating a private practice in Saint Vincent has led to competition between providers, primarily based on cost. The competition has also led the private medical sector to provide services not offered by the public sector. For example:

- Some private providers offer advanced treatment not available in the public sector. For example, private sector dentists offer root canals, advanced extractions, crowns, and emergency treatment, as well as advanced imaging and orthodontics.
- Some private physicians offer monthly cardiology and neurology services through visiting specialists.
- Some private providers offer preventive screening tests that improve prevention efforts for infectious disease such as HIV, tuberculosis, hepatitis C, and dengue fever.
- Private labs are able to provide faster response times to doctors for test results.
- Private sector services provide references and help create contacts to off-island specialists.
- Private pharmacies offer a wider variety of branded medication than available in the public sector.

Most private services (outside of pharmacies) are located on the main island of Saint Vincent. Private providers are available in the Grenadines, including Mustique. Mustique Island is owned by the Mustique Company, which employs a doctor and nurse to provide clinic care at free and subsidized prices to the residents and workforce of the island. The clinic runs special screening days for diabetes and has the ability to do EKGs and x-rays. More complicated cases are referred to the MCMH. Private physicians operating on the other Grenadine islands are primarily dual practice, or private physicians that travel from Saint Vincent to the smaller islands on a regular basis. These providers serve the island's residents as well as visiting tourists.

There is no routine formal survey documenting utilization of health care services in the private health sector. However the 2007/08 Country Poverty Assessment (Kairi Consultants Limited 2009) indicates that 21 percent of survey respondents overall reported that private providers were the first source of care, and 9 percent reported seeking care from foreign private providers. For both categories, percentages increase with income. For more information on these results, please see Chapter 5, Service Delivery.

9.1.2 COST OF SERVICES

There is limited data on what private sector services cost. While all providers have set rates, they are generally adjusted based on a client's ability to pay. According to some physicians interviewed, private health care services are more expensive than they should be for the services provided. Physicians report that price comparison shopping for medical services is a common practice among residents of the islands.

9.2 PRIVATE SECTOR ROLE IN THE SUPPLY CHAIN

The private sector serves an important role in the medical supply chain by providing convenient access to a choice of medical products supplies. Moreover, price margins on private sector medical products are regulated and the 13 private pharmacies compete on retail price. Overall, this regulation and competition benefits consumers. Many Vincentians seek help for medical concerns at private pharmacies before going to a clinic or doctor.

9.2.1 PRIVATE PHARMACIES

Thirteen private pharmacies are listed in the Saint Vincent Yellow Pages. Most are located in Kingstown, with others throughout the islands of Saint Vincent and the Grenadines. According to interviews conducted for this assessment, the industry has grown substantially since the late 1990s when there were just two private pharmacies operating in Saint Vincent.

Opening a pharmacy requires that owners have a business license and a registered pharmacist on staff. Some pharmacy operators feel that political differences have influenced their ability to obtain or the speed at which they could obtain a pharmacy license. Apparently, the greater business challenge is finding enough licensed pharmacists in the country. Some private pharmacies employ pharmacists who are non-Vincentians. Many public sector pharmacists reportedly also work in the private sector; they complete their required hours of work at the public sector facility and then work a second job as a pharmacist in the private sector.

Pharmacies provide a range of products that are not available in the public sector, especially for branded treatments. Over-the-counter medicines such as aspirin and ibuprofen are sometimes out of stock or more expensive at public health centers. Nonpharmaceutical products such as cosmetics, food, and school supplies have become as important for these businesses as the prescribed drugs that they sell. Private pharmacies are motivated to serve clientele as quickly and rapidly as possible. Some offer additional services like blood pressure screening on a regular basis. As businesses, they are focused on retaining clients, and this motivation manifests itself in competitive prices and focused customer service.

Little regulation is imposed on pharmacies in Saint Vincent. For example, some private providers offer pharmaceutical products through pharmacies attached to their practice. At the Mustique Clinic, where there is a lack of other commercial or noncommercial offices to provide separate pharmaceutical distribution, the medical doctor is responsible for dispensing pharmaceuticals. The Planned Parenthood clinic offers contraceptive products which they source from Trinidad and supply to clinic patients as well as other pharmacies on the island. The top selling products for all pharmacies were hypertensive and diabetes medications according to nearly all pharmacists interviewed. ARV drugs are not regularly stocked at private pharmacies, but could be ordered through private pharmacies for clients that requested and paid for them.

Private pharmacies are regulated by the Drug Inspector, but the proposed regulations which would strengthen the ability of the Drug Inspector to enforce private sector regulations have still not taken effect. Draft legislation to strengthen the regulatory process has been waiting in Legal Affairs for approval since 2006. For more information on the status of these regulations, please see Chapter 7, Management of Pharmaceuticals and Medical Supplies.

9.2.2 PHARMACY DISTRIBUTORS AND WHOLESALERS

Pharmacies obtain supplies through local distributors or wholesalers. There are several wholesalers on the island who import products from a variety of sources. Three distributors (Shepherd's, Coreas, and Bryden) represent some of the major international pharmaceutical lines. Wholesalers procure from a variety of locations, including the U.K., the U.S., Trinidad, and India. To import pharmaceutical products, the importer must have a registered wholesale pharmacy business, apply for a license to import the products, and obtain a pharmacist's signature at the time of customs clearance. Also, the MOHE has included distributors and wholesalers in the pharmacovigilance efforts, when expired, tampered, or damaged medications are identified. Beyond these relatively simple requirements, there appears to be little regulation of importers or wholesalers.

In terms of drug pricing, importers must pay product cost, insurance, and freight fees for product shipments, as well as taxes, customs duties, and customs service charges. The product is then marked up by the wholesaler/distributor and the retailer. All of these fees add up to as much as 44 percent mark-up on the original product cost according to one licensed wholesaler who was interviewed. Retail prices for medicines in pharmacies appear competitive, due to the number of pharmacies in Saint Vincent.

9.2.3 MEDICAL SUPPORT SERVICES

Medical services such as private labs also play a role in the health supply chain since they supply services to private providers. Labs feature a variety of blood tests, ranging from the standard to more complex. The labs sign contracts with local providers, guaranteeing them prompt service for a discounted fee. These contracts ensure the volume necessary to run a profitable lab business.

Labs own (or lease) and maintain the machinery necessary for the tests. Private lab services have sometimes filled needs for the public sector, proving more reliable when testing machinery at the hospital is not operating or when the hospital is out of regents for testing. One lab owner, who formerly worked at MCMH, explained to the assessment team that the hospital may own testing machinery, but it does not always pay the expensive annual maintenance fees. When equipment breaks down, the public sector incurs significant time delays, waiting to obtain the approvals to incur the repair costs. Private labs cannot afford to rely on this strategy since broken equipment would result in immediate loss of business. One lab owner interviewed reported that 25 percent of his total business was referrals from the public hospital when equipment there was out of commission. The lab owner suggested that he would be interested in offering lower fees to the government in exchange for a negotiated contract for services or for concessions on taxes for the importation of certain products. It may be worthwhile for the government to explore the use of private lab services for more complex blood testing, as well as the costs and benefits of subcontracting testing considering the high operational cost of equipment and maintenance contracts.

9.3 GOVERNANCE AND POLICY ENVIRONMENT

While the private sector is independent from the government, medical provider ethics require adherence to Vincentian laws and regulations which are in place to protect its citizens. Government policy can both strengthen and stifle the private sector – the ideal is to balance its responsibility to citizens as well as to the private sector so that it may grow profitably and provide economic growth to the country as a whole. When optimized, an organized private sector can be an active participant in the health system and a resource partner to address the country's health needs.

In Saint Vincent, the private health sector largely operates independently from the public sector, even though it is partially composed of practitioners from the public sector. There is little regulation by and no formal engagement with the MOHE. This independence is beneficial for business, but does not ensure that quality health care is delivered to Vincentians. For the most part, the professional councils do not engage in regulation or set quality improvement standards. Some professional councils offer active support and guidance to their members, but they largely act as registration bodies that validate credentials for doctors, nurses, pharmacists, and dentists.

9.3.1 PUBLIC-PRIVATE ENGAGEMENT TO DEVELOP POLICY

For the purpose of this assessment, public-private engagement is defined as the active discussion and collaboration of organizing bodies of private sector representatives and groups about issues that relate to the health of Vincentians as envisaged in the MOHE Strategic Plan for Health.

The SVG Medical Association, which includes all doctors and dentists, is primarily a registration body for medical practitioners. The association has promoted medical education and courses to its membership, as well as opportunities to provide services for charitable causes. The association has taken a lead in strengthening medical credentials by promoting ethical standards for care. It has also attempted to engage with the MOHE on policy discussions to address the modern medical sector in Saint Vincent by drafting new legislation to more comprehensively cover medical practice by including a broader range of medical providers (such as radiologists, specialists, and technicians). Given the composition of membership in the association, with both public and private practitioners represented, the association

would seem to be ideally placed to facilitate public-private engagement for strengthened health care delivery in Saint Vincent. However, though it appears on the SVG Medical Association website, 2005 draft legislation has not been passed and remains in the Attorney General's office for approval. Also, the SVG Medical Association is not mentioned as a key partner in MOHE strategic documents, and stakeholders interviewed for this assessment did not appear to see it as an important organization.

Based on interviews conducted, business and industry as a whole appear to be absent from the health policy dialogue in Saint Vincent. The Saint Vincent and the Grenadines Chamber of Commerce has been invited to participate in MOHE strategy development, but has not actively participated or attended meetings. The Chamber of Commerce represents the island's broader business interests, composed usually of small and medium enterprises. According to interviews with its current President, the Chamber has been fairly weak over the past few years and has not actively engaged with the MOHE on health-related issues.

The exception to engagement on policy seems to have been the discourse related to HIV, especially during the active Global Fund grant periods. As part of the HIV response in Saint Vincent, line ministries have engaged with community service organizations and the private sector to address HIV issues under the National Strategic Plan for HIV/AIDS. The SVEF, which represents 50 of the country's industrial enterprises, collaborated with the Ministry of Labor to draft legislation for occupational safety and against discrimination toward PLHIV in the workplace in 2009. The draft legislation is currently in the Attorney General's office.

Apart from the examples noted here, there does not appear to be a forum for regular dialogue with the MOHE to shape and inform health policy.

9.3.2 REGULATION OF THE PRIVATE SECTOR

Official oversight and regulation of private providers rests with the MOHE (through the CMO). The Medical Registration Act of 1886 sets up the regulatory practice for medical care, including private physicians. Medical practice in Saint Vincent is organized around three professional councils: the General Medical Council (covering medical doctors and dentists), and the Nursing and Pharmacy Councils. To become a private physician, registration with the Medical Council and the MOHE is required, as well as a business license.

Other medical practitioners and establishments, such as lab technicians, diagnostic centers, nursing homes, and occupational therapists are not included. Due to lack of regulation, a business can be established without proof of credentials for these professions. According to one member of the SVG Medical Association interviewed for this assessment, draft legislation based on the CARICOM Act to update laws governing the establishment of medical practice was submitted to legal affairs in 2006 and has not yet been passed.

Private pharmacists must be registered with the MOHE and have a license to operate from the Pharmacy Council and the MOHE Division of the Environment. Licensing grants the right to dispense pharmaceuticals and requires an annual fee payment to the MOHE. It appears from interviews with key stakeholders that the licensing requirement is loosely enforced. For more information on pharmaceutical governance, please see Chapter 7, Management of Pharmaceuticals and Medical Supplies.

No providers interviewed could recall active regulation enforcement from the MOHE and several stakeholders voiced concern about the need to update regulations and the lack of regulation enforcement. A strengthened regulatory practice was viewed by the interviewees as the ability to prohibit and close unethical medical practices and businesses. Several providers acknowledged that it was important to report notifiable diseases to the MOHE (HIV, tuberculosis, hepatitis, dengue fever), but that it was not actively done by all providers, nor was there active enforcement by the Chief Epidemiology Officer.

9.3.3 DUAL PRACTICE

Engaging in dual public/private practice appears to be the norm among medical practitioners in Saint Vincent. When asked how many public sector doctors also practice in the private sector, the response from interviewees for this assessment was usually “all of them.” The dual practice structure, as in other OECS countries, seems to allow public sector facilities to attract and retain doctors, despite low government salaries. Currently, there seem to be an estimated 42 doctors working in both the public sector and the private sector, and they account for essentially half of all doctors and the majority of public sector doctors (PAHO 2010b).

Among the private practitioners interviewed, there is a perception that dual practitioners have the advantage in carrying out a lucrative medical practice in Saint Vincent, since business risk and financial investment are much lower for dual practitioners than for providers operating purely in the private sector. Also, private sector physicians are limited in growth because regulations do not allow them to use public hospital facilities for surgery, thus limiting the scope of private practice on the island to nonsurgical activities. There is also the sense among the doctors interviewed that dual practice physicians can offer lower prices, attracting clients away from a purely private sector practice. According to some private providers, dual practice physicians can afford to lower their rates, as they receive a base salary from the MOHE. This dynamic may be inadvertently subsidizing private health services, by offering rates that do not completely reflect the cost of doing business, and which may undercut private sector practitioners who must bear the full cost.

9.4 PRIVATE FINANCING FOR HEALTH

Little data on the private contribution to health care financing in Saint Vincent was available to this assessment team. Because Saint Vincent has not conducted a population-wide household health expenditure survey independently or as part of a general NHA analysis, the only estimates of OOP payments are imputed figures from the WHO Global Health Expenditure Database. These data show that all private health expenditures are OOP (i.e., little to no private expenditure is pooled through insurance premiums), and that as a percentage of total spending, OOP spending has risen from 36 percent in 2000 to 43 percent in 2009. However, it should be noted that these data are not consistent with the Country Poverty Assessment finding that 9.4 percent of the population is covered by insurance, nor the presence of four insurance companies currently providing coverage to Saint Vincentians. Nevertheless, from these data and interviews conducted for this assessment, it appears that despite the almost-free cost of health care in the public sector, a significant number of Vincentians incur discretionary spending in health, primarily for: pharmaceutical products purchased from private pharmacies, private provider fees, and, most importantly, the costs of critical or tertiary care. The latter involves overseas travel to seek medical care, typically from a private health facility.

With the exception of the social insurance scheme that provides some standard income replacement and compensation benefits (though not general health benefits), health insurance provision in Saint Vincent is currently run by four private insurance companies: Sagicor, Coreas, CLICO, and BAICO. These companies cover the estimated 9.4 percent of the population in Saint Vincent that reported holding health insurance (Kairi Consultants Limited 2009). Of those covered, the majority are those who have formal employment-sponsored insurance. The Country Poverty Assessment documents that coverage rates increase with income, with coverage at 4.3 percent in the lowest income quintile and 24.3 percent in the highest. Table 4.2 in Chapter 4, Health Financing, shows a breakdown of these coverage data.

The four insurance companies that provide health coverage have introduced a lifetime maximum coverage for PLHIV. There is however a wide disparity between companies. One company's lifetime maximum was set at EC\$50,000 while another was set at EC\$10,000. Both of these maximums are significantly lower than the major medical lifetime maximum of EC\$1 million offered at Sagicor. It is

unlikely that the lifetime maximums for PLHIV are sufficient to support a person living with HIV over the long term given the need for chronic treatment including ARVs.

Recent financial failures in two of the four companies have required regional and national responses and carry implications for insurance holders in Saint Vincent. BAICO and CLICO, both operated by a regional conglomerate based in Trinidad and Tobago, were declared insolvent and are currently under judicial management at the regional level. The collapse of these companies has affected multiple Caribbean countries, creating confusion and concern about how to reimburse policyholders and pay outstanding claims. In mid-2011, eastern Caribbean governments launched the much-anticipated BAICO Health Insurance Support Fund that will provide some relief for policyholders. Additionally, the government of Saint Vincent recently established an EC\$5 million medical insurance fund to cover holders of BAICO medical insurance in the country (Chance 2011b). Trinidad and Tobago's government is paying EC\$33 million to bail out CLICO, and in April a regional high court appointed a judicial manager to recover some of CLICO policyholders' assets.

Despite these regional and national responses, some interviewees for this assessment reported that these failures have resulted in a lack of confidence in private insurance companies, and several private insurance providers confirmed during interviews that the failures have resulted in significant fallout. However, this opinion was not consistent across all interviews, with some arguing that the failures did not impact the confidence levels of the population significantly.

In addition to these four private insurance companies, some larger employers (e.g., employing more than 200 workers) offer health insurance to their employees including benefits for tertiary and off-island care. For example, the Mustique Company offers primary health services for 1,600 employees and residents on Mustique Island. Preventive and simple services are free when accessed during normal hours, and emergency and nonregular-hour visits require only minimal fees. Fees for the doctor, medications, and support are paid for by the Mustique Charitable Trust.

9.5 CONTRIBUTIONS OF PRIVATE COMPANIES TO HEALTH

The assessment team found that companies in Saint Vincent contribute both cash and in-kind to public health clinics and facilities. The sum and scope of the contributions are not well documented, but should be, as they contribute to the delivery of services that are envisioned in the MOHE's health strategy.

While many private sector contributions appear to be charitable, there is also a growing awareness of the importance of public health, especially in workplace programs. As a result, organizations are also strategically contributing.

9.5.1 CHARITABLE CONTRIBUTIONS

Some examples of charitable programs include:

- Rotary clubs in Bequia have contributed equipment to the local health clinics
- The Mustique Charitable Trust equipped the neonatal intensive care unit at MCMH and is funding a pediatric surgeon at MCMH, and, along with Rotary, has funded numerous medical missions for pediatric surgery for seven years
- A local radio program has provided free air time for 20 years to the MOHE for a health and wellness promotion program
- Scotiabank funds the Bright Futures program which includes health education to youth at risk
- Trinity School of Medicine supports district health officers in Calligua (and the proposed Stubbs Polyclinic) by providing junior faculty and visiting professors support to the clinics, and carries out health fairs and educational fairs throughout the island

9.5.2 STRATEGIC CONTRIBUTIONS

An example of a more strategic contribution is that of Trinity School of Medicine, which pays an annual fee to MCMH for the right to collaborate with the hospital for education purposes. The school also provides local public sector doctors with the opportunity to learn from visiting doctors and provides local doctors with the opportunity to lecture and supplement their income. Currently, the Trinity School of Medicine is co-funding a pediatric surgeon with the Mustique Charitable Trust to work at MCMH.

9.5.3 WORKPLACE PROGRAMS

Some organizations that would traditionally fall outside of the health sector are still actively engaged in health issues. WIFA is one such organization. As a regional association, WIFA has a presence in Saint Vincent, Saint Lucia, and Dominica. WIFA advocates for tighter integration between the agricultural and health sectors, and works to educate its membership about environmental health issues, as well as HIV and prevention of heart diseases and diabetes. These programs have been funded by members, with collaboration from the MOHE, which sends nurses and education specialists to support the programs when requested.

The Ministry of Tourism collaborated with NAS to carry out workplace training of major tourist operators and hotels for HIV prevention and stigma reduction. These trainings are still in place and are largely funded by the large tour operators. Larger resort companies have developed workplace health and wellness programs that cover HIV prevention and education, programs on healthy eating and exercise, and screening for diabetes and blood pressure. These efforts support the MOHE's wellness strategy, but they have not been developed with MOHE leadership, nor are they measured for their effectiveness.

The SVEF, which represents 50 small and medium enterprises in Saint Vincent, is leading the country's employers in the development of HIV workplace policies. This work has been funded by the regional ILO since 2005 and to date over half of SVEF's member companies have drafted workplace policies.

In summary, employers seem active in promoting health, wellness, HIV stigma prevention, and providing other similar services in the workplace. Many companies are eager to make a contribution toward health and wellness for their employees, but are not always aware of the health education needs, gaps in their programs, and opportunities for external collaboration. The MOHE Division of Health Promotion could provide the leadership for these companies to understand the health needs of their populations and link the program with national health and wellness priorities. Collaboration would mutually benefit companies and the MOHE by developing effective corporate health communication platforms to reach Vincentians, without consuming additional MOHE operating resources. For this to happen, the benefits of sharing information and collaborating need to be tangible and mutually understood. Understanding the investment by companies in these programs, as well as their value (whether it be charitable, educational, or strategic), would help assert their value in the eyes of the government, and might lead to a more constructive engagement with the private sector about improving health in the country.

9.6 PUBLIC-PRIVATE ENGAGEMENT

Broader public-private engagement, outside of policy, appears to be limited in Saint Vincent. No mechanism exists to support such efforts, and previous efforts appear to have been based on individual relationships.

Areas where the private sector in Saint Vincent has engaged with the public sector include:

- Services for health education and nursing support in workplace activities as described above
- Subcontracted services not available in the public sector

- Actual public-private partnerships

9.6.1 SUBCONTRACTED SERVICES THROUGH THE PRIVATE SECTOR

The MOHE informally engages with the private sector, often for one-off services in a subcontracting relationship. By more actively and openly discussing these types of relationships, the MOHE could identify alternative solutions and resources for reaching its priority objectives and maximize the resources available on the island. In order to do so, the MOHE needs to clarify its top priorities, because approaching public-private partnerships without linking them strategically to objectives might create a burden of management on the public sector rather than a mechanism for increasing resources for public providers and increasing access for the public. Strategic planning on how to utilize subcontracting will also require that the MOHE understand health cost centers, and the tangible and intangible costs of subcontracting.

9.6.2 PUBLIC-PRIVATE PARTNERSHIP: THE WORLD PEDIATRIC PROJECT

The WPP, an international NGO active in Saint Vincent, is particularly notable and may generate significant opportunities to advance the public health sector in Saint Vincent. The WPP has established a public-private partnership with the government of Saint Vincent and the Mustique Charitable Trust. With its partners, the WPP will build a wing attached to MCMH to serve as a center for pediatric surgery for the region. The partners will create a distinct non-profit corporation, with a board composed of the partnerships' members, which will oversee implementation. The corporation will own and operate a surgical wing that will provide tertiary care for children selected for operations in Saint Vincent, and children from other OECS countries. Implementation will progress in stages, starting with the remodeling of several operating theaters in the existing hospital, to the eventual construction of the hospital wing. At the writing of this assessment, the WPP reported that a Letter of Intent formalizing the terms of the partnership was being prepared.

Despite the generosity of the partners and the admirable vision of this project to provide pediatric surgery for the region's children, it is not clear if the MOHE has identified the full costs and potential financial value of the partnership. It appears that all parties agree on the goals of their partnership, but do not necessarily recognize their financial commitment or the value of in-kind resources that they will contribute. Specifically, the MOHE has committed to providing land, hospital services, and use of the surgical wing for these surgeries. However, according to the WPP, there is a sense that the full value and cost of this commitment have not been recognized. The WPP is eager for the MOHE to have a clear understanding of its cost commitment so that implementation can move forward and support a sustainable program in the long run. Additionally, while contributions from the MOHE may be in-kind, they should bear a value, especially when they represent operating and opportunity costs that will be dedicated to a project that is outside the scope of national strategic plans. The valuation of benefits should outweigh the economic costs, and in a public agency, should not drain resources.

After meeting with the Director of the WPP, it remained unclear to the assessment team who will bear additional operating costs (from MCMH) associated with the center (e.g., lab, diagnostics) for non-Vincentians. The time is ripe for the MOHE to engage with the WPP, to ensure that this promising partnership strengthens the island's health care system. Potential opportunities for the MOHE to work with the WPP may include building capacity of MCMH staff in critical care surgery, negotiating use of the wing (when not used for medical missions) for private provider surgeries, recuperating the full costs of MCMH services used by non-Vincentians, and finally ensuring that the new wing does not drain MCMH's already-stretched resources. The directors of the WPP appear open to receiving inquiries from the MOHE and the government, but report that to date, such requests have been limited.

9.6.3 FACILITATING PUBLIC-PRIVATE ENGAGEMENT

Public-private engagement in the past has grown organically, based on opportunities that are mutually interesting and obvious. In those cases, professional and social networks have facilitated engagement of various parties. More actively seeking public-private engagement has not traditionally been a role of any organization or company, but many are finding that they have mutual interests and could bring complementary assets to create better solutions than those created through independent efforts. This engagement requires an intermediary who can identify stakeholders and bring them together in a structured dialogue to consider such partnerships. While few channels and organizations exist to facilitate ongoing public-private engagement, three groups have the potential to further these discussions in the future. The SVG Medical Association should provide a forum for discussions among public and private practitioners, since both are members. However, given the competition on the island as well as opinions about dual practice, it appears that the Medical Association avoids any engagement that could lead to confrontation and may not have the staffing and expertise to actively convene partners. Despite these issues, its mission, membership, and institutional role make it the best-equipped group for facilitating discussions on engagement in the medical sector.

Other potential conveners of this discussion might include the Saint Vincent Chamber of Commerce or SVG Invest. The Chamber of Commerce traditionally represents Vincentian companies and it has clear experience negotiating and managing business propositions. SVG Invest is a parastatal arm of the Ministry of Finance, and is set up to seek and identify partnerships with outside companies for investment in Saint Vincent. Each of these groups could serve as a neutral facilitator but would not have the background in health and health needs that might be beneficial to envision how partners might collaborate.

9.6.4 OPPORTUNITIES FOR PUBLIC-PRIVATE PARTNERSHIP

In addition to those mentioned above, other opportunities for partnership identified during the assessment include:

- Tightening collaboration between the MOHE and SVEF to establish workplace policies and programs for HIV in businesses as well as to promote diabetes and blood pressure screening
- Identifying opportunities for subcontracting services that may be more cost-effectively delivered in the private sector (some lab and diagnostic services, mosquito control for dengue)
- Strengthening the SVG Medical Association to include quality improvement services and communicate regulatory enforcement
- Pooling private sector purchases of paramedical products through CMS, and private sector purchasing at a small profit to the CMS (as in Dominica)
- Strengthening ties with Trinity Medical School and SVG Medical Association to carry out accredited continuing medical education

9.7 RECOMMENDATIONS

The following summarizes the recommendations regarding the private sector.

9.7.1 SHORT-TERM RECOMMENDATIONS

Conduct a baseline mapping of private sector services and resources as a foundation for increased engagement

Given the recent growth of the private sector, a mapping of providers and services will provide the MOHE with a better understanding of both the range of services and numbers of providers operating in the private sector. The mapping effort should include identification and classification of dual practice operators, and could be expanded to include all stakeholder involved in providing health services to citizens to identify gaps in services. The mapping will also help identify the level of specialization, equipment available, services offered, staffing, and location of each provider. The MOHE could contract a local consultant to compile this inventory within a relatively short period of time. Such a document would allow the MOHE to engage in an effective discussion regarding regulation, collaboration, and effective health provision through public and private sectors.

Review and clarify existing and pending legislation for medical service registration and regulation of private sector physicians and services

In order to advance the issue of updating the registration and regulation of private sector physicians, even legislation that may not be completely current may serve the system better than not having legislation in place and embarking on a long process to develop new legislation.

Initiate dialogue between the public and private sectors to identify collaboration opportunities and to develop longer-term plans and health strategies

Convene a meeting with leaders in the public and private sectors, led by a neutral facilitator, to determine how best to engage key stakeholders in the group. The success of this effort may require identifying a person who is a focal person within the MOHE to maintain engagement and integrate ideas and solutions identified through this forum throughout the ministry.

Coordinate health promotion and wellness activities with industry, workplace, and nongovernmental organization programs

The MOHE and the Division of Health Promotion should convene a meeting of private companies that are already engaged in health promotion according to a theme (e.g., diabetes, HIV/AIDS), in order to understand the scope, investment, and populations covered by larger corporate health promotion programs. Understanding current activities, their cost, and the gaps that could be addressed through MOHE leadership would serve as an immediate guide to the MOHE in ways to build the value of these programs.

Explore partnerships with the private sector that maximize resources for both the public and private sectors

Review the plans for the WPP to determine the implication for MOHE services and the recovery of costs for services provided to non-nationals. Determine if there are opportunities within the WPP for the MOHE to take on a greater role or from which it could derive benefit.

Through meetings to convene partners and programs, identify the priority areas for strategic engagement and value-added. Technical assistance could help identify priority programs and areas for strategic engagement and establishing a process and strategy to advance the search for and development of public-private partnerships.

Identify services in the private sector that may be able to fill gaps in public provision through negotiated contracts

Examples may include back-up lab support services for nonroutine lab work, medical education, and environmental health services.

9.7.2 LONGER-TERM RECOMMENDATIONS

Develop and enforce guidelines on dual practice in the public and private sectors

As part of the MOHE's human resource planning, the MOHE should address the factors that contribute to distortions in provider incentives to serve private patients at the expense of public service. Factors include standards, evaluation, and working conditions.

The challenge of strengthening regulatory requirements is a regional one. Opportunities exist for sharing best practices for strengthening and enforcing regulatory requirements in the region and helping the MOHE develop guidelines for regulation enforcement.

Engage key private sector leaders in the development of strategic public health plans

In particular, articulate the role of the private sector during the planning process and how their responsibilities will be operationalized.

Review and enact the specific requirements and process for enforcing legislation

The framework and operations for regulating providers and services should be developed and communicated to the private sector. As discussed, draft legislation based on the CARICOM Act to update laws governing the establishment of medical practice was submitted to legal affairs in 2006 and has not yet been passed, and overall active regulatory enforcement from the MOHE has been insufficient to ensure good medical practice and facilitate cooperation and sharing among private practitioners.

Expand health promotion and wellness activities with industry, workplace, and nongovernmental organization programs

The MOHE could help companies to evaluate private sector programs, determine the value of their contribution, and decide whether the effort to strengthen outreach through the private sector is strategic. Establishing the capacity to evaluate the results of such programs will inform their expansion. Technical assistance could support strengthening the Chamber of Commerce to develop evaluation frameworks and assess the overall contribution of these programs.

Develop and advance opportunities for the private sector to utilize unused capacity at the Milton Cato Memorial Hospital, or to grow specialty practices with support from the public sector

The private sector is leading the effort to bring specialties to the island. When demand is sufficient, private providers often organize to fly specialist doctors such as cardiologists and orthodontists from overseas with benefits for all actors involved: providers in Saint Vincent and the foreign specialists make a profit, consumers save money, as the cost of receiving care in Saint Vincent is lower than the combined cost of transport and services abroad, and the country overall gains as health care availability increases. Private sector providers involved in managing this type of exchange can share lessons learned about bringing needed specialty services to the island. Formal agreements from the MOHE to subcontract underutilized surgical space for private sector use extend collaboration between the sectors and help the MOHE determine how the public sector can integrate critical specialties cost-effectively.

10. SYNTHESIS AND CROSS-CUTTING THEMES

This report has focused on the six building blocks of the health system, as well as the role of the private sector in each of those areas. Specific findings within each of the six building blocks are important to address individually. However, there are a number of key, interrelated issues that limit the health system's ability to offer sustainable, quality health services. The assessment found that while the health system in Saint Vincent functions well, there are key areas that could improve the delivery of health care. Addressing these challenges holistically will result in positive and sustained impact, and contribute to a more effective health system in the long term. Overall, the assessment team identified the following key cross-cutting themes:

- Efficiency in public health care and referral systems
- Availability and use of key data in planning
- Dialogue and partnership with private health sector stakeholders
- Revision of critical health policies and acts

These cross-cutting themes and corresponding recommendations, first presented in the Executive Summary, are presented in more detail in Table 10.1.

TABLE 10.1: CROSS-CUTTING RECOMMENDATIONS

Efficiency in public health care and referral systems	
Findings: <ul style="list-style-type: none"> • The Saint Vincent health system is providing comprehensive and effective coverage for primary care services to its population even though the system must serve multiple islands. • Providing diagnostic services and secondary and tertiary care in a cost-effective and high-quality manner remains problematic, though its importance in Saint Vincent has increased with the growing burden of chronic NCDs. • The MCMH is overutilized for primary care and rural hospitals are underutilized, though supporting patients with chronic NCDs in the communities where they live would be more cost-effective. 	Recommendations: <ul style="list-style-type: none"> • Develop an enforceable referral policy to divert patients away from the MCMH and to the health clinics (or the new Stubbs Polyclinic) for appropriate outpatient and after-hours primary care. For example: <ul style="list-style-type: none"> • Impose and collect higher user fees on patients who choose to bypass the local primary care facilities in favor of MCMH. • Implement a rotating phlebotomy service to facilitate the drawing of blood at health clinics/district hospitals, which could then be taken to MCMH for lab tests. • Leverage the roll-out of the SVGHIS across all public health facilities; with the SVGHIS, test results can be electronically reported back to primary health care sites and could support a referral program.
Availability and use of key data in planning	
Findings: <ul style="list-style-type: none"> • There is insufficient bandwidth and capacity at the MOHE to compile and report the routine health data reported from health clinics and hospitals in Saint Vincent. <ul style="list-style-type: none"> • Data are not evaluated and analyzed in 	Recommendations: <ul style="list-style-type: none"> • Initiate a costing exercise to begin documenting the cost of providing key health services across multiple settings, both public and private, and use data to compare costs, health outcomes, and budgetary allocations. The MOHE can use this comparison to:

<ul style="list-style-type: none"> a timely manner. Data are not disseminated for use by stakeholders. Data are not used to inform decisions about management, budgeting, and strategy development to the extent that they could be. Development of analytical and planning capacity at the MOHE is made more challenging as strong advocacy to fund this development requires data analysis. There is limited data availability on health expenditures, particularly by households and the private sector, and on the costs of service delivery at health care facilities. <ul style="list-style-type: none"> No general NHA has been conducted. The HIV/AIDS NHA subaccount covering 2004 was helpful but needs to be updated. 	<ul style="list-style-type: none"> Identify services that are most cost-effectively provided, which will inform decisions on allocation of public health resources Inform human resources planning, including the development of an HRH strategic plan Inform discussion of user fee structure reform Conduct an NHA analysis, including spending on HIV/AIDS and household OOP spending. The MOHE can use this data to inform discussions and policymaking about: <ul style="list-style-type: none"> Budgeting reform: moving away from historical budgeting to evidence-backed allocations Sustainability planning at the MCMH User fee reform NHI Institutionalize capacity for costing and NHA so that expenditure information is routinely available for evidence-based planning.
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Dialogue and partnership with private health sector stakeholders

<p>Findings:</p> <ul style="list-style-type: none"> There are several examples of private sector medical practices supporting provision of health services to Vincentians in a way that benefits the public interest while also satisfying business needs. <ul style="list-style-type: none"> Mustique Company owns and operates Mustique Clinic, which provides care for insurance-holding employees but is also open to all other residents and tourists. The WPP, an international NGO, will provide specialty pediatric services at MCMH in collaboration with other public and private partners. While there is some collaboration between the sectors in Saint Vincent, the public sector could do more to leverage this potential. 	<p>Recommendations:</p> <ul style="list-style-type: none"> Formally designate and empower a staff member within the MOHE to act as the public-private liaison. The primary objective of this role would be to foster a collaborative dialogue between the MOHE and private sector entities to plan, evaluate, and support health improvement activities across Saint Vincent.
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Revision of critical health policies and acts

<p>Findings:</p> <ul style="list-style-type: none"> Key legislation providing effective oversight guidelines, responsibility, and authority is outdated, with consequences for the efficiency and efficacy of Saint Vincent's health system. Two particularly critical examples concern regulations linked with the Pharmacy Act and regulation of the private health sector. The current Pharmacy Act defines how to register and open a pharmacy, but does not structure the process by which pharmacies 	<p>Recommendations:</p> <ul style="list-style-type: none"> Review and update central components of the health sector regulatory framework. <ul style="list-style-type: none"> Engage in collaborative dialogue with the Attorney General's office Consult with public and private providers and the Medical Councils to identify and catalog the legislation that needs to be updated most urgently The MOHE should negotiate cost recovery policy with private sector providers using public sector facilities to ensure that their collaboration is sustainable.
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should be monitored, evaluated, or sanctioned, and the regulations linked with the Pharmacy Act have not been passed.

- The Medical Registration Act of 1886 sets up the regulatory practice for medical care, including private physicians, but no private providers interviewed could recall active regulation enforcement from the MOHE and several voiced concern that, without updated regulations and better enforcement, it was hard to close unethical medical practices or facilitate data-sharing and cooperation among practitioners.
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ANNEX A: REPORT ON THE HEALTH SYSTEM AND PRIVATE SECTOR ASSESSMENT VALIDATION AND PRIORITIZATION WORKSHOP IN SAINT VINCENT AND THE GRENADINES

BACKGROUND

Saint Vincent and the Grenadines is one of 12 Caribbean countries joining efforts with the United States Government in the United States-Caribbean Regional HIV and AIDS Partnership Framework 2010–2014 (Partnership Framework). The United States Agency for International Development (USAID) is working through two projects, Health Systems 20/20 and Strengthening Health Outcomes through the Private Sector (SHOPS), to provide a variety of health systems strengthening technical assistance to countries in the eastern Caribbean as part of this Partnership Framework. To identify priorities for this technical assistance, the two projects conducted integrated health systems and private sector assessments in the six Organization of Eastern Caribbean States (OECS) countries. Additional partners in this effort included the Pan American Health Organization (PAHO), the International Training and Education Center for Health (I-TECH), and the Caribbean HIV/AIDS Regional Training Network (CHART).

The assessment in Saint Vincent and the Grenadines was a first step towards improving its capacity to effectively lead, finance, manage, and sustain the delivery of quality health services. Inherent in the country's capacity to carry out these roles is an understanding of how to catalyze private sector contributions to health. While the functioning of the broader health system was the focus of the assessment, particular attention was paid to sustaining the country's HIV response.

The assessment process allowed the government of Saint Vincent, USAID, and other health partners to better understand the key constraints in the health system and prioritize areas that need greater attention. The assessment also creates a road map for local, regional, and international partners, both public and private, to coordinate technical assistance.

The assessment process had four phases. The initial step was a meeting in July 2011 to engage stakeholders and reach consensus on the topics that would require the most attention during the assessment. An extensive literature review was conducted during the second phase, which involved conducting interviews with over 90 stakeholders and site visits to health facilities across Saint Vincent and the Grenadines during one week in July/August 2011. Following this, the assessment team drafted a report which was shared with the Ministry of Health, Wellness and the Environment (MOHE) for review in December 2011. The final stage, which is represented in this workshop report, was the validation and prioritization of the report findings held from February 29 to March 1, 2012. The results of this workshop will inform revisions to the draft report and the prioritization of technical assistance that USAID and other partners may provide in the region.

OPENING REMARKS AND PRESENTATION OF FINDINGS

The Chief Medical Officer (CMO), Dr. St. Clair Thomas, opened the workshop by welcoming participants and thanking them for coming. He introduced the Health Planner of the MOHE, Ms. Lucine Edwards, who lead a prayer and the Saint Vincent national anthem. Following this, Dr. Thomas introduced the new Minister of Health, Mr. Clayton Bergin, who thanked everyone for their engagement with this assessment process. He reviewed ongoing initiatives such as the Survey of Nutrition, Health, and Disease and the roll-out of an electronic health information system. Mr. Bergin also discussed some of the key challenges in the macroeconomic environment and in the changing epidemiological landscape that make reaching policy goals both necessary and challenging. Mr. Bergin, holding this post for only a week before this workshop, stated that he was looking forward to future collaboration with the health sector stakeholders present and that he hoped that the workshop would help point the way forward. He thanked USAID and other PEPFAR partners for their work on this assessment and in gathering stakeholders for this workshop.

Ms. Elizabeth Macgregor-Skinner, workshop facilitator from the SHOPS project, introduced the objectives and agenda of the workshop and began individual participant introductions. In addition to stating their name and organization, participants were asked to identify their main concern for the health system in Saint Vincent. Several people mentioned challenges with management of human resources (HR) at the Milton Cato Memorial Hospital (MCMH). Another commonly raised concern was increasing usage of health financing and planning tools for program sustainability and cost recovery.

Following the welcome and introductions, Mr. Michael Rodriguez from Health Systems 20/20 highlighted the key findings and recommendations presented in the assessment report. The findings and recommendations presented covered the World Health Organization (WHO) building blocks of health governance, health financing, human resources for health (HRH), service delivery, pharmaceutical management, health information systems (HIS), and the private sector. Within each topic, findings related to the private sector's role were also discussed. Participants asked questions to clarify the findings and recommendations.



The Chief Medical Officer Dr. St Clair Thomas introduces the Honorable Minister of Health, Mr. Clayton Bergin

VALIDATION OF FINDINGS AND RECOMMENDATIONS

Discussion of key findings in assessment report

Following the presentation of the findings, participants were asked to consider the key findings and recommendations in the assessment report. Participants formed small groups based on their interest in particular health system building blocks. The groups reviewed the report to verify that findings matched their experience and to add any points that they felt should have been included. The small groups focused on the following building blocks: (1) health financing, (2) HRH, (3) service delivery, (4) governance, and (5) HIS issues and pharmaceutical management. Participants reported that the findings were generally accurate and made the following suggestions for strengthening each module:



Permanent Secretary Shirla Francis discusses health financing findings and recommendations with Kevin Farara from Caribbean HIV/AIDS Alliance and Jeanie Olivier of the Saint Vincent and the Grenadines Human Rights Association

Additions and edits to findings	
Health Financing	<ul style="list-style-type: none"> • Discussion of a national health insurance (NHI) plan was not developed into specific, actionable “plans;” the discussion would be better characterized as “explorations.” • Other findings are accurate.
Human Resources	<ul style="list-style-type: none"> • Revise the second finding to state that, though the Public Service Commission (PSC) is implementing SmartStream, the human resources component of SmartStream is currently underutilized. This issue is being addressed through external assistance (E-GRIP). Also, it would be best to replace PSC with the Service Commission Department (SCD), a constitutionally autonomous department. • Revise third finding to state that, while there is adequate voluntary counseling and testing (VCT) capacity, capacity for provider-initiated treatment and counseling needs to improve. • The fifth finding is accurate, but it should be noted that the HR module in SmartStream will include an alert function in advance (1–2 years) of someone’s retirement, which will trigger succession planning. • The seventh finding should make it clear that regulations on dual practice do exist, but they are not specific enough. • During the discussion of HR management and development policy, the report states that one does not exist. However, since the assessment, a draft has been developed and is currently being reviewed by Cabinet.
Service Delivery	<ul style="list-style-type: none"> • The HIV posters are not isolated to hallways at MCMH; they are not specific to clinics. • It is worthwhile noting the absence of a national quality improvement plan. • Other findings are accurate.
Governance	<ul style="list-style-type: none"> • There was some debate about the status of the Freedom of Information Act (FOIA), that is whether it has been passed and whether it has been implemented. In the end, the information in the report was verified as an accurate representation, but the report should be more detailed: the act was published in 2003. However, the act contains a clause stating that “the act shall come into operation on a day to be appointed by the [Prime] Minister, by order published in the Gazette.” So far, this has not taken place. • Other findings are accurate.
Health Information Systems	<ul style="list-style-type: none"> • For the first finding, coverage for SVGHIS was at 70 percent in August 2011 when the assessment was completed. Since then, this number has increased to 80 percent of the facilities in the country covered by the SVGHIS and includes the Grenadines. • The second finding that technical infrastructure in Saint Vincent is secure is not entirely accurate. There are still a number of unsecure facilities housing information technology equipment. • With reference to the third finding, since August 2011, two permanent staff have been established in the Health Planning and Information Unit, but additional staff are still required for sustainability. • With reference to the fourth finding, while the lack of a single patient identifier number remains an issue, under E-GRIP there is a project for developing a multipurpose ID to address the issue of a single patient identifier.
Pharmaceutical Management	<ul style="list-style-type: none"> • Some participants questioned the validity of the finding about limited training on ARVs for MCMH pharmacists. It might be worth clarifying in the report that these findings were based on discussions with patients, nurses, and other stakeholders rather than pharmacists. • Other findings are accurate.

Private Sector	<ul style="list-style-type: none"> • While not specifically addressed as a building block or through a separate group, feedback regarding the private sector is captured here: • Since the writing of the report, the World Pediatrics Partnership (WPP) has not advanced given lack of response from the government. There seemed to be some miscommunication among partners as to the willingness to cooperate to bear recurring costs in a sustainable financing plan. The Mustique Charitable Trust is now planning a phased approach to investing in a new hospital wing. As a result, the WPP is looking to adopt a more regional approach to surgeries, with some taking place in Saint Vincent and others in other islands and with each island serving as a pediatric specialty hub. • Since the writing of the report, a new private hospital reportedly opened in the Arnos Vale area. The owner contacted the CMO to acquire the procedure for registering a private hospital. The CMO reported that Saint Vincent did not have any established procedure for a private medical facility registration. To address this problem, the CMO gave the new hospital owner the policy for registering a facility from Grenada and suggested that the owner follow the same procedure. Stakeholders felt that the lack of clear and established procedures for private medical establishment may serve as a barrier to establishing similar ventures and does not ensure that quality standards are met.
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DISCUSSION OF RECOMMENDATIONS

The small groups then discussed the assessment's recommendations. The groups considered whether the recommendations addressed the key findings presented, whether there were any concerns about the recommendations, and finally whether there were any recommendations that were missing. The participants agreed with the recommendations listed and added or further specified some recommendations. The following table summarizes the groups' feedback.

additions and edits to recommendations	
Health Financing	<ul style="list-style-type: none"> • Standardize the rules behind exemptions as user fees currently account for an insignificant part of health sector revenue overall. Improve the user fee rules and enforcement so that they can become a better source of revenue. Also, conduct a comprehensive study to see where the loopholes are. • Make a sharper distinction between the use of public facilities by dual practice doctors serving private clients (as a private physician). While private user fees are collected from private patients, the doctor acting in the context of a private physician is treated like a public physician by the hospital while being paid a private fee by the patient. Fee structures should recuperate the cost of the facility use by the private physician in this case, which is only partially borne by the patient. Doctors might allocate some of the fee they collect to the hospital for this type of facility use. The physical separation (separated wing) for private sector patients might allow this type of policy to be enforced more easily. • Review available health financing data and current collection processes with a view to identifying appropriate health financing datasets. • Move forward with public and private health sector collaboration, spearheaded by the Permanent Secretary; provide more incentives for the private sector to get them to work with the public sector to make more advanced services available on the island. Also, develop a private/public collaborative strategy that will benefit both parties. • Any plans to conduct a National Health Accounts (NHA) now should be part of a larger institutionalization strategy. • Continue exploring the idea of an NHI; in particular, try to identify a broad package/basket of services.

Human Resources	<ul style="list-style-type: none"> • With reference to the first recommendation on streamlining the hiring process, it should be noted that some efforts have begun to initiate that process. • With reference to the recommendation on rationalizing nurse training needs, in the supporting details for this recommendation, add the need to address long-term succession planning (e.g., five years in advance of expected retirements due to the long training process to ensure adequate expertise). • Revise recommendation on clarifying the responsibilities of public health professionals who have private practices. The recommendation should state which health professionals are permitted dual practice. • Increase the level of sensitization on existing regulations. • Expand the scope of the Division of Nursing Education to include allied health, to provide basic training and specialized training for other health professions (e.g., nutrition, dental, health education, and environmental health). • MOHE should collaborate with Trinity School of Medicine and All Saints Medical School for HR capacity building in health specialty areas and direct service provision. • Advocate for University of the West Indies to open campus to offer distance learning opportunities in allied health. • Create an HR management unit within the MOHE.
Service Delivery	<ul style="list-style-type: none"> • Endorse the recommendations in the assessment report. • Develop a holistic plan for integration of primary health care with specifications on trained personnel, sensitization, stakeholder involvement, legislative framework, and policies and standard operating procedures. The plan should also include clauses for mental health and persons with disabilities. • Create more posts and more opportunities for training. • Develop a National Quality Improvement plan. • Revise standards with a view to accreditation. • Develop protocol for clinic management.
Health Information Systems	<ul style="list-style-type: none"> • Endorse the recommendations in the assessment report. • It is important to note that, since August 2011, the HIS Group has initiated dialogue with St. Lucia and Belize to establish ways to assist each other in capacity strengthening and sharing of lessons learned. • Buy-in from stakeholders in relation to the SVGHIS and perceived benefits is not high and needs attention. The MOHE HIS Unit may need to look at engaging stakeholders and users beyond simply educating them and consider incentives to ensure that users enter data properly.
Governance	<ul style="list-style-type: none"> • With reference to the long-term recommendation on considering new MCMH governance models, it is worth noting that health sector stakeholders have already engaged in extensive discussions on this topic. The problem is not that they have not considered new options but that, after considering, no steps are taken to move forward on new plans. The recommendation should be revised to focus on reactivating the committee established for this work and to have this committee advocate for and push forward stages of implementation to unify and streamline hospital management.

Pharmaceutical Management	<ul style="list-style-type: none"> Regarding the first recommendation on developing standard treatment guidelines, it should be noted that such guidelines do already exist for chronic noncommunicable diseases, but need updating to reflect current protocols. The recommendation to hire pharmacy students to help address inventory management of pharmaceuticals in district hospitals and clinics might be better if it favored pharmacy technicians, who, while less credentialed than pharmacists, have more experience and would require less training and active management than students and probably provide higher-quality labor. Some in the group felt that it was not necessary to collaborate with the private sector to supplement the Essential Medicines List. Ensure quality assurance and safety of medication (especially for donated drugs, as no policy or standard exists). Also, drug registration in the island or the region is currently nonexistent and labs and structure cannot currently manage. This could be a regional issue.
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DISCUSSION ON CRITERIA FOR PRIORITIZATION

After agreeing on additions and changes to the findings and recommendations, the participants developed a set of criteria for prioritizing the recommendations in a plenary session. The group agreed that priorities would be based on whether the recommendations were (1) realistic, (2) affordable, (3) impactful, (4) data-driven, and (5) transformative. A **realistic** recommendation would require that the timing is appropriate and there is the appropriate mix of skills available to carry out the activity (on-island or available through technical assistance). **Affordable** would mean having the funds to both start and sustain an activity. In looking for **impact** the participants wanted the activity to be both highly visible and truly make a difference in the health system. **Data-driven** refers to interventions that have scientific evidence behind them, have current data available to support their need, and have measureable impact. Participant also wanted to see interventions that were **transformative** and represent a change in the way things have been done before. Some participants suggested that “sustainable” should also be a criteria, but the group debated whether “sustainability” was a description of the context and commitment in which a recommendation would be followed or of the recommended action itself. In the end, “sustainability” became a criterion to apply when the context made it appropriate.



Mrs. Audrey Gilkes, Chief Nursing Officer, Dr. Simone Keizer-Beache, Medical Director at MCMH, and Mr. Cuthbert Knights, MCMH Hospital Administrator, prioritize governance recommendations

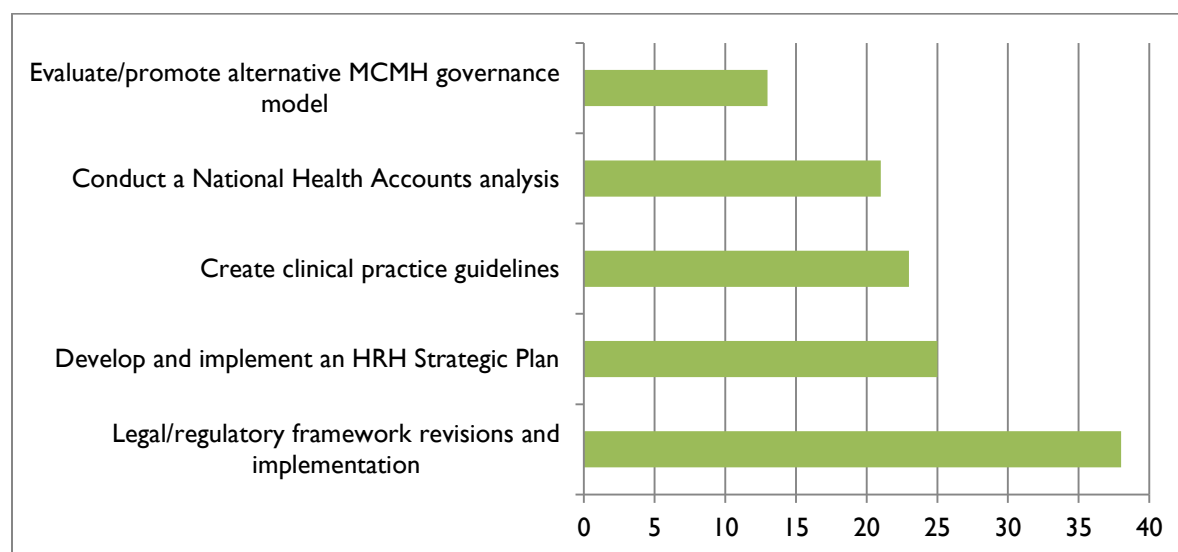
ALIGNMENT OF PRIORITIES TO ONGOING MINISTRY OF HEALTH, WELLNESS AND THE ENVIRONMENT INITIATIVES

The process for prioritizing recommendations in Saint Vincent had two parts. First, in small groups participants prioritized three to four recommendations within a given health systems building block and recorded them on flip charts. Following this, each participant was given five “votes” (i.e., stickers) to prioritize recommendations across the health sector as a whole. After walking around the room to review the prioritized recommendations for each building block, participants voted for sector-wide priorities by placing their stickers next to their selected recommendations. Participants could use more than one vote for any given recommendation. During the evening reception that following the first day of the workshop, the Health Minister, Mr. Bergin, the Permanent Secretary, Ms. Francis, and the Health Planner, Ms. Edwards, all of whom had other duties during the late afternoon when voting took place,

were able to place their votes. The results of the first stage in prioritization are summarized in the table below.

Governance	Health Finance	Service Delivery	Human Resources for Health	Pharma and Supplies	Health Information System
Revise regulatory framework and implement legislation to support the health system	Conduct broad, systematic review of health finance options	Develop clinical practice guidelines to promote quality of care	Develop and implement HR management strategic plan	Fast track review of Pharmacy Act Regulations	Develop staffing plan to support SVGHIS
Improve mechanisms for citizen and civil society engagement	Conduct NHA analysis	Implement supportive supervision and quality improvement	Update legislation regarding providers to include continuing education requirement, licensing, and disciplinary procedures	Develop standard treatment guidelines to promote quality of care	Build electronic reporting platform to explore e-reporting of syndromic surveillance data
Consider alternative hospital management models at MCMH	Develop health financing strategy	Promote use of rural hospitals and clinics (over Accident & Emergency at MCMH)	Coordinate to clarify roles of HR information system	Increase budget control for Central Medical Stores and labs	Pool resources with St. Lucia to share best practices
		Standardize exemption policies for priority health areas			

The results of the second and final stage in prioritization are summarized in the figure below.



At the beginning of discussions on the second workshop day, Ms. Macgregor-Skinner reviewed these results. Participants were then asked to join a group to discuss a priority of interest to them. Using an action planning worksheet, participants considered any differences and overlaps of the priority recommendation with ongoing MOHE and PAHO initiatives and identified additional actions and resources needed to implement and champion each recommendation. During the group discussion on the revisions and implementation of legal/regulatory frameworks, group members decided that, for all relevant legislation, the bottleneck for legislative approval is primarily insufficient staff in the Attorney General's office. As a result, this priority recommendation was reframed as one of strengthening ties to the Attorney General's office and advocating for a series of specific revisions.

A summary of these discussions is presented in the tables below.

Priority Recommendation: Strengthen ties with the Attorney General's office to prioritize and pass key legislation (such as the Pharmacy Act); implement new legislation and legislative updates to strengthen governance structures.

1. Fast-track Pharmacy Act Regulations
2. Pharmacy Act
3. Mental Health Policy Guidelines/Act (finished; with legal affairs)
4. Tobacco Control Guidelines
5. Registration and regulation of health providers and facilities
6. Draft policy on national medicine, food additives and nutrition, drug misuse and prevention act

What ongoing initiatives already support this priority area? (e.g., MOHE, PAHO, others)	What action steps have already been proposed?	Who will "own" (lead or champion) the next steps?	What resources are needed? What external resources could be mobilized?
1. Pharmacy Council (legal officer) working with Attorney General on Pharmacy Act Regulations. CARICOM – Harmonization of Services	<ul style="list-style-type: none"> Pharmacy Council has sent amendments to the drafted act and regulations Dialogue with Attorney General's office on fast-tracking 	Pharmacy Council (Chairperson)	<ul style="list-style-type: none"> Legal consultant attached to MOHE who can work on health legislation only for a limited period of time to work and advocate within Attorney General's office for health-related draft bill passage Engage services of Caribbean Association of Pharmacists to sensitize stakeholders Through Pharmacy Association, engage pharmacy owners to advocate for legal passage Mobilize private interest through the Chamber of Commerce Mobilize Bureau of Standards and Bureau of Consumer Affairs to look at Media bill for false advertising
2. Mental Health Policy Act Drafted by committee and rests in the Attorney General's office since 2009; awaiting review	<ul style="list-style-type: none"> Mental Health Services is following up 	Mental Health Services	Ask PAHO for technical assistance for the Attorney General's office to review the mental health laws

3. Tobacco Control <ul style="list-style-type: none"> • Tobacco Framework Convention on Tobacco Control ratified by the state • Participated in Global Youth Tobacco Survey with preliminary results that show tobacco use data for decision makers • CARICOM initiative to develop standards of packaging and labeling of tobacco products 	<ul style="list-style-type: none"> • Develop legislation for tobacco control • PAHO workshop to develop legislation on tobacco control scheduled March 16, 2012 	Health Promotion Unit	Assistance from PAHO is planned
<p>3. Draft key legislation</p> <p>In order to regulate and register providers – some legislation has been drafted; some is still in development</p>		CMO	
What additional concrete next steps are needed?			
<ol style="list-style-type: none"> 1. Articulate case for the immediate passage of the Pharmacy Act in a separate memo to the MOHE in order for it to get on Cabinet Agenda – by April 1st 2012 (by Pharmacy Council) 2. At quarterly Pharmacy Association meeting – specifically reach out to pharmacy owners for support of the memo (requires preparation to get them to attend the meeting through specific agenda and identifying private pharmacy owner/champion) – April 2012 (by Pharmacy Association) 			
<ol style="list-style-type: none"> 1. Mental Health – Continue to develop and refine policies for mental health policies by September 2012 (Draft) 2. Attend stakeholder meeting on mental health policy in March 2012 			
<ol style="list-style-type: none"> 3. Tobacco Control <ul style="list-style-type: none"> • Attend the PAHO Coordinators' Workshop in March 2012 • Write report on the results of the Youth Tobacco Survey • Disseminate results of the Youth Tobacco Survey to stakeholders 			

Priority Recommendation: Develop a Human Resources for Health strategic plan

What ongoing initiatives already support this priority area? (e.g., MOHE, PAHO, others)	What action steps have already been proposed?	Who will “own” (lead or champion) the next steps?	What resources are needed? What external resources could be mobilized?
<ul style="list-style-type: none"> • PAHO/SVG biennial work plan • 2007–2012 National Health Strategy • PAHO 20 Goals Baseline on HRH (conducted in 2010) • PAHO HRH core dataset activity (conducted in 2009) • PEPFAR regional partnership framework (SVG work plan) • HR module of SmartStream 	<ul style="list-style-type: none"> • HR module of HIS (led by MOHE) • PAHO technical assistance • I-TECH/CHART are in the process of organizing a workshop to strengthen HRH planning and management in OECS • OECS HIV/AIDS Project Unit to hire an HRH technical advisor to OECS members, supported by I-TECH/CHART 	<ul style="list-style-type: none"> • MOHE: Permanent Secretary, Health Planner, CMO • MOF: Central Planning • SCD • Ministry of Education (MOE) • Ministry of Legal Affairs • Private sector • Educational institutions 	<ul style="list-style-type: none"> • Technical assistance (e.g., PAHO, OECS, EU, I-TECH, CHART, World Bank, CARICAD, UWI) • Funding (e.g., to convene meetings) • Dedicated time by team members • People
What additional concrete next steps are needed?			
<ul style="list-style-type: none"> • Schedule meeting between MOHE, MOF, MOE, SCD, PAHO, I-TECH/CHART, and others to come to agreement on the way forward and map out timeline • Identify/designate HRH strategic plan project manager • Establish team (see “owners”) • Develop planning timeline • Develop/acquire tools for HRH planning • Train key team members in HR planning and management • Review existing data and ongoing initiatives to inform HRH strategic plan (e.g., 20 Goals Baseline, Core dataset) • Consultation sessions with stakeholders • Develop HRH strategic plan 			

Priority Recommendation: Create clinical practice guidelines

What ongoing initiatives already support this priority area? (e.g., MOHE, PAHO, others)	What action steps have already been proposed?	Who will “own” (lead or champion) the next steps?	What resources are needed? What external resources could be mobilized?
PAHO <ul style="list-style-type: none"> Essential Medicines List Vulnerability assessment Facility assessment Safe hospital index Policy development OECS / PPS Clinical management guidelines for HIV and STIs for all OCS countries Guidelines for <ul style="list-style-type: none"> HTN, DM, asthma Food safety Immunization Drug Formulary CHART I-TECH USAID Management of TB/HIV Caribbean Guidelines 2010 MOHE Antibiotic policy guidelines Nursing Procedure manual Patient and ward audit	<ol style="list-style-type: none"> Update medical emergency guidelines (disease specific protocols) – MCMH and out-of-hospital cases Develop medical and nursing protocols Develop national HIV/AIDS policy guidelines (legal, PMTC, VCT, treatment protocols, notification guidelines) Guidelines to monitor treatment and management of health of patients in nursing homes, children’s homes Prescription practice guidelines Regularly scheduled audits Computerized system for protocols Clinical M&E guideline Family planning clinical guidelines Orientation of medical personnel to available guidelines 	<ol style="list-style-type: none"> MOHE – Permanent Secretary CMO Health Planner Clinical Pharmacist Chief Pharmacist Protocols – Medical Association of St. Vincent National Laboratory QA Coordinator – monitor public and private labs Corresponding working groups Human Rights groups N.B.: Social Worker suggested 	MOHE Funding: PAHO, WHO, EU, TSOM, HIV funding agencies, USAID, other medical schools (e.g., All Saints), PEPFAR, UNICEF, NGOs, UNFPA, UWI HR <ol style="list-style-type: none"> Technical coordination Statistician – MOHE M&E – M&E and Quality Unit N.B.: Still a need to expand the contribution from each of the stakeholders
What additional concrete next steps are needed?			
Form a technical working group to review existing guidelines and prioritize guidelines to be worked on for the next two years.			

Priority Recommendation: Conduct a National Health Accounts analysis

What ongoing initiatives already support this priority area? (e.g., MOHE, PAHO, others)	What action steps have already been proposed?	Who will “own” (lead or champion) the next steps?	What resources are needed? What external resources could be mobilized?
<ul style="list-style-type: none"> • Health Planner and EU discussions • PAHO and USAID are involved in supporting NHA regionally 		<ul style="list-style-type: none"> • Permanent Secretary • Health Planner • CSOs • Private sector 	<ul style="list-style-type: none"> • UWI • MOHE (Permanent Secretary, Health Planner) • Statistical Office • Educational • Finance and Planning • EU • PAHO • USAID • Brazil
What additional concrete next steps are needed?			
<u>Preparing for the analysis</u> <ul style="list-style-type: none"> • Create a Cabinet-approved committee inclusive of private and NGO sectors to further discuss this question; this would be a long-term committee, not just for this one round of NHA. Deputy Chair must be from an NGO. The committee should also have a representative from all ministries; the number of public sector reps should be equal to the number of CSO reps. • Make sure the surveys capture issues specific to Saint Vincent so that data collected can be used to disaggregate expenditures properly. • MOHE should advocate for funds to conduct this analysis. • Make sure institutionalization is part of the discussion, that is, that steps are taken to create framework to ensure that the committee and NHA initiative will be continued past round I. 		<u>Conducting the analysis and using the results</u> <ul style="list-style-type: none"> • Mapping of resources: how much is coming from where and where is it going? • Surveying the demand (user) end • Including data from insurance • Identifying what services were accessed and where they were accessed • Disseminating the results widely • Using data in M&E and other ways to improve transparency and accountability • Looking at findings and recommendations from analysis and implementing them 	

Priority Recommendation: Restructure the governance of Milton Cato Memorial Hospital

- Appoint a single leader (CEO)
- Develop and authorize distinct budgetary control for supplies, equipment
- Structure a Board of Directors with CEO reports to board

What ongoing initiatives already support this priority area? (e.g., MOHE, PAHO, others)	What action steps are being proposed?	Who will “own” (lead or champion) the next steps?	What resources are needed? What external resources could be mobilized?
<ul style="list-style-type: none"> • World Bank [timeline: 5 year] is providing ~\$27 million in a grant/loan to view the vulnerability reduction: mitigating against things like hurricane, infrastructure <ul style="list-style-type: none"> ○ Health services systems analysis, which includes structure of/location of facilities ○ Will look at whether hospitals should become part of a separate management group within MOHE, should district hospitals and clinics be grouped together, etc. • PAHO: Safe Hospitals initiative <ul style="list-style-type: none"> ○ Disaster plans: facility’s ability to respond to and recover from disaster • WPP initiative: <ul style="list-style-type: none"> ○ Centered in SVG, but potential to move hub to other island – can it be leveraged as a potential loss to advocate for governance changes? ○ Maintenance is a problematic issue ○ PR opportunity to advocate for importance of the hospital ○ Loss of program would also mean sending children off-island, spending more resources – cost-benefit analysis to SVG? <ul style="list-style-type: none"> ▪ Some data exists on sending people off-island (CT SCAN analysis?) 	<ol style="list-style-type: none"> 1. Develop an advocacy plan to other key stakeholders/ constituencies: <ul style="list-style-type: none"> ○ MOHE ○ NIS (Mr. Reginald Thomas, Executive Director of the NIS) ○ Private sector providers ○ Private insurance companies ○ Private suppliers 2. Arrange a meeting with the Permanent Secretary, Health Planner, department heads 3. Arrange a meeting with new Health Minister 4. Have the new Health Minister promote the idea to the Cabinet 	<ul style="list-style-type: none"> • Dr. Keizer, Medical Director; Mr. Knights, Hospital Administrator; Margaret Edwards, Senior Nursing Officer (Senior Management Committee) 	<ul style="list-style-type: none"> • Research materials (Hospital Governance Report – Mr. James from Barbados) • Examples of why the current structure does not work • Examples from other islands: e.g., Barbados • Stats on order fill times for supplies, staffing, HR management challenges, etc. • Technical assistance to help organize advocacy plan, develop costing plans for the hospital (current vs. reorganized structure)

NEXT STEPS AND CLOSURE

After the presentation of action steps by each group, Health Systems 20/20 and SHOPS thanked participants for their engagement in the validation and prioritization process. Health Systems 20/20 and SHOPS will use results of the workshop to revise factual mistakes in the assessment report. The final report with priority recommendations highlighted will be shared with USAID's implementing partners in the region as well as other U.S. government agencies working in the region, PAHO, the OECS, and UNAIDS, to further align technical assistance with the country's needs. MCMH Hospital Administrator Mr. Cuthbert Knights added a word of thanks to participants for their enthusiasm and USAID for creating the opportunity to discuss priorities.



Elizabeth Macgregor-Skinner talks with Dr. Shakel Henson from the Trinity School of Health

ANNEX B: KEY ISSUES REGARDING HIV/AIDS IN SAINT VINCENT AND THE GRENADINES

WHAT IS THE PROBLEM?

The Caribbean region has the highest incidence of HIV/AIDS in the Americas and the second-highest prevalence in the world after sub-Saharan Africa. As of 2010, 1,218 HIV cases have been reported in Saint Vincent and the Grenadines (hereafter Saint Vincent), while 575 deaths have been attributed to AIDS. Based on data from antenatal clients, HIV prevalence is estimated to be around 1 percent of the population, on par with the Caribbean average, and the main mode of transmission is heterosexual contact. According to a World Bank report (2011), in 2011 there were 175 people living with HIV (PLHIV) receiving antiretroviral treatment (ART) in Saint Vincent.

WHO LEADS THE HIV/AIDS RESPONSE?

The Ministry of Health, Wellness and the Environment (MOHE) in Saint Vincent established the National AIDS Program (NAP) and its secretariat (NAS) to facilitate a coordinated response to the epidemic and to serve as the focal point for the collection and dissemination of information about HIV, AIDS, and other sexually transmitted infections. NAS is tasked with implementing the National Strategic Plan for HIV/AIDS 2010–2014, which outlines five priority areas for preventing and mitigating the effects of HIV and was drafted with input from a range of stakeholders including government ministries, civil society, and the private sector.

WHO SUPPORTS THE RESPONSE?

Numerous faith-based and civil society organizations (CSOs) provide HIV/AIDS-related health education and support services. Many target vulnerable populations such as youths and men who have sex with men. Among the most prominent CSOs are Planned Parenthood, Population Services International, and the Caribbean HIV/AIDS Alliance. The Saint Vincent and the Grenadines Human Rights Organization promotes the civil rights of PLHIV by defending them in court cases on discrimination and by challenging policymakers to provide better legal protections for PLHIV. Additionally, a National Network of NGOs was established in 2002 in response to a perceived need by national NGOs for coordination of HIV activities; the network now has 15 members. The private sector is also an active player, addressing HIV/AIDS through the Employers' Federation and developing HIV/AIDS workplace policies in 16 workplaces supported by the International Labor Organization. Public sector health facilities provide counseling, testing, and treatment services (described below), while some private clinics also provide treatment for PLHIV in Saint Vincent.

WHO FUNDS THE RESPONSE?

Though external resources for health make up only a small part of Saint Vincent's total health expenditure, between 2005 and 2011 the HIV/AIDS program in Saint Vincent received US\$7 million from the World Bank and approximately US\$1.3 million from the government of Saint Vincent. Additionally, U.S. government agencies have supported HIV-related activities through the President's

Emergency Plan for AIDS Relief (PEPFAR), providing a total of US\$2 million in grants during the two-year period 2010–2011.

According to the World Bank's 2011 evaluation of its HIV/AIDS Prevention and Control project, the MOHE made significant progress over this period on several key indicators: the number of reported new HIV cases declined by 41 percent and the number of new AIDS cases declined by 56 percent. Regional programs and domestic contributions have also supported the HIV response in Saint Vincent. The Caribbean Community (CARICOM) and the Organization of Eastern Caribbean States (OECS), with Global Fund grants, have subsidized the cost of antiretroviral drugs (ARVs), which are available free of charge in Saint Vincent's public sector; Brazil contributes by supplying ARVs annually, with shipment costs supported by UNICEF.

With the completion of the World Bank-funded program in 2011 and with remaining resources from both the Global Fund and Brazil to end in 2013, questions remain about the sustainability of Saint Vincent's HIV/AIDS program. Government budget projections indicate that government support for the HIV/AIDS program will level off in the coming years at around US\$200,000 per annum; Saint Vincent has not formulated a strategy for filling the resource gap.

WHERE AND BY WHOM ARE HIV/AIDS COUNSELING AND TESTING SERVICES PROVIDED?

Efforts to integrate voluntary counseling and testing (VCT) services into primary care services are currently underway, especially through the introduction of provider-initiated testing and counseling. The World Bank 2011 evaluation reports that the number of individuals tested for HIV reached 8,927 for the period January 1, 2010 through September 30, 2010, far exceeding the target of 2,000; and the number of public facilities staffed by trained counselors providing specialized HIV counseling and testing reached the target value of 39 (18 of these facilities provide rapid testing). According to objectives set out in the country's National Strategic Plan for HIV/AIDS, rapid testing should be made available at all health clinics. Private labs also currently provide general and rapid HIV testing. However, a recent health systems and private sector assessment found that, even though some rural hospital staff had been trained to provide VCT, stock-outs of tests and frequent relocation of trained staff made providing rapid tests challenging.

Public sector treatment and care for HIV/AIDS are centralized at Milton Cato Memorial Hospital (MCMH). These public services are almost entirely free of charge for patients. The National Strategic Plan for HIV/AIDS lays out plans to establish three additional ART sites within the next two years and three more in following years. All PLHIV who attend a public clinic for care and treatment are assessed regarding their social, economic, and psychological status. Financial assistance is provided through the Ministry of National Mobilization. Priority for financial assistance is given to orphans, the physically impaired, and the elderly. Assistance is provided in various forms, such as school lunches, school supplies and school fees, monthly stipends, and monthly food packages. Travel reimbursements for eligible clients also exist. However, during the recent assessment, PLHIV reported a decrease in these support services in recent months.

WHAT IS THE LEGAL FRAMEWORK FOR PROTECTING PEOPLE LIVING WITH HIV?

No HIV-specific legislation, regulation, or policy in Saint Vincent currently protects the rights of PLHIV, provides mechanisms for reducing discrimination in institutional settings, or provides sanctions for health workers who discriminate or stigmatize PLHIV, such as through a breach of confidentiality. PLHIV are protected generally under current labor laws, as are all citizens of Saint Vincent, but are not listed as a protected class. According to interviews conducted for the assessment, the absence of these specific

protections discourages individuals from seeking counseling and testing services, as many clients are fearful that they will be discriminated against if they are found to have HIV.

HOW IS HIV/AIDS DATA GATHERED AND SHARED?

HIV/AIDS data are gathered from a wide variety of sources across Saint Vincent and in a wide range of formats. Monthly VCT and treatment statistics are reported by health facilities, while the national lab at MCMH compiles the majority of the testing information. Health facilities report through the Health Planning and Information Unit, while test results are generally sent directly to NAS. NAS facilitates the sharing of HIV/AIDS data to key stakeholders and the reporting of key indicators to funding partners.

HOW CAN THE HIV/AIDS RESPONSE BE STRENGTHENED?

Several interventions can be implemented in an effort to improve the HIV response in Saint Vincent and the Grenadines. The assessment team recommends the following actions, in order of importance:

Develop HIV-specific legislation that explicitly forbids discrimination in the workplace and in health care settings, while also laying out the responsibility of the government in providing support to PLHIV. Regulations and policies outlining the types of sanctions employers and workers might face if they are found to have discriminated against PLHIV would help to clarify the legal situation for these cases.

Reorganize the MCMH outpatient specialty clinic in order to reduce stigma. Rather than having a separate wing with exam rooms for HIV/AIDS patients only, the exam rooms should be interchangeable with the other specialty services rooms provided in the clinic. In addition, conducting an HIV stigma self-assessment could help MCMH identify other areas for reducing HIV stigma.

ANNEX C: WORLD BANK HEALTH FINANCING INDICATORS

TABLE C1: SELECTED ECONOMIC AND HEALTH EXPENDITURE INDICATORS, SAINT VINCENT AND THE GRENADINES, 2000–2009

Indicator	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total expenditure on health as a percentage of GDP	5.6	5.6	6.0	5.9	5.9	5.8	5.9	5.3	5.2	5.6
Government expenditure on health as a percentage of total health expenditure	64.0	64.3	66.8	67.5	63.2	62.9	64.6	61.2	61.9	56.6
Government expenditure on health as a percentage of total government expenditure	10.8	10.1	10.7	11.0	9.8	10.4	11.2	9.5	9.5	9.5
Social Security expenditure on health as a percentage of total health expenditure	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Private expenditure on health as a percentage of total health expenditure	36.0	35.7	33.2	32.5	36.8	37.1	35.4	38.8	38.1	43.4
Private prepaid plans as a percentage of private Expenditure on health	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
OOP expenditure as a percentage of private health expenditure	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
External resources for health as a percentage of total health expenditure	0.0	0.0	0.0	0.0	0.0	0.0	1.3	2.5	2.4	2.3
Per capita total health expenditure at average exchange rate (US\$)	176.0	183.0	207.0	211.0	230.0	238.0	269.0	272.0	279.0	301.0
Per capita government health expenditure at average exchange rate (US\$)	296.0	307.0	346.0	361.0	403.0	416.0	475.0	481.0	486.0	518.0
Per capita government health expenditure (PPP international \$)	189.0	198.0	232.0	244.0	255.0	262.0	306.0	295.0	300.0	293.0

Source: World Bank (2011a)

ANNEX D: BIBLIOGRAPHY

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